			1 - For State Registrar	State of Maryland	-	artment of H			ene g. No 2005	29501
	Physici	an	1. Decedent's Name (First, Middle, Las	1	Sa			2. Date of Death Month	Day Year	3. Time of Death
1	/Medic	al	4a. Facility Name (If not institution, give	street and number)	<u> ≥e.</u>	4b. City, Town, or	Location of Death	JEPI.	4c. County of Dea	ath
			Manor Car	e Rossvill	10	If Under 1 Year	If Under 24 Hrs.			more
	Funeral Director		5. Social Security Number 6. S 210-12-7604	ex M 2□ F 7. Age (In yrs. II	S Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) 9. 50	rthplace (State or Foreign country)
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits
	a-f eho	tor	MD Balt	imore.	Dur	dalk				1 Yes 2 No
	death with the Maryland ma 23a or 28a-f ehow rmust be notified at	Director	10e. Street and Number	1		10f. Zip Code		10	g. Citizen of What (Country?
	ma 23	Funeral	11. Marital Status	12. Was Dependent Ever in U.: Armed Forces?	<i>142</i> S. 13.	2/22 Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-	14. Race - Arr Black, Wh	nerican Indian,
36	o 72 hours after death with the Marylan "naturel", or flema 23s or 28s-1 ehow selical Examiner must be notified at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No		1 ☐ Yes 2 ☑ No	Specify:	110211, 01017	Specify: ()	4
5-0036	72 hou nature	eted	15. Decedent's Ed (Specify only highest gra	ducation	(Give	dent's Usual Occupa	luring most of work	ing 1	6b. Kind of Busines	s/industry
121		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	i de	DO NOT use retired	lerk		Post o	office.
nd 2	ges 1 and 2 should be filed within to of Heath and Mental Hygiene. If item 27 is marked other than or other traumatic event, If a M.	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, N	faiden Sumame)	0.77
Maryland	should nd Men marke imatic	2	William E. 19a. Informant's Name/Relationship (19b. Maili	ng Address (Street a	and Number or Rui	al Roote Number,	City or Town, State	, Zip Code)
	is 1 and 2 soft Health are item 27 is other trau		Earl W. Sm.	ith	9	TREEN	Ct,	Balto.	, mo:	21236
nore	ages 1 int of H t: If iten y or oth		20a. Method of Disposition 1	Removal from State	emetery, cre	osition (Name of matory or other plac	e) 5000	L 7 745	C. Location - City o	or Town, State
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licer		lawey		ss of Facility - MSh	TON FL	weral	Home, P.A.
	200		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line.	n. Do not en				, ,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	100	KIA				Onset and Death
	/Medical Examiner			Due to (or as a consequence HYOC	uence of):	INL I	~ For	CTION	(
	ed sit	iner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury	Dua to (or as a nonsec)	ianna of)r					
ζ,	ate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	C Due to (or as a consequence	uence of):					
8760	cate be physicia the bur	dicai	•	_ d	.	-				
Box 6	death certific e attending p od for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		⊒Ectopic pregnancy			23d. Date of	
.O. B	w requires that the death cerlific been signed by the attending p should be detached for use as	Completed by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of d		Other (specify)			Month	Day Year
Δ.	requires that the een signed by th nould be detache	y Ph	Part II. Other significant conditions of			underlying cause give	en in Part I.			to the cause of death?
ord	require	eted 1	AIZHEIMER ASPRATION	S DEMEN	JIA.			-		Probably 4 Dunknown
Rec	he law e has b age 2 s	omple	K SILMITION	MENHO	OIA			24a. Was a autops perform	y prior t ned? death	autopsy findings available to completion of cause of ? es 2 \[\sum No \]
/ital	clan: 1 ertificat ector, pa	Be	25. Was case referred to medical examiner?					th (Check only on		85 21 110
of \	Physic r this c aral dire	ပို	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatie	Transfer of the second	442 Nursing H		nce 6 Other (S	pecify)
ion	Attending r death. sctor: After oy the fune	ation	1 Natural 5 Pending 2 Accident investigation	n	Injury		k? Yes 2 ☐ No			
Division of Vital Records,	l or Att	Certification;	3 Suicide 6 Could not b 4 Homicide determined		ome, farm, si	reet, factory, office		28f. Location (St City or Town	reet and Number or n, State)	Rural Route Number,
	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C		nysician: To the best of my kno niner: On the basis of examina and manner stated.						
	To the within To the comp	Me	29b. Signature and title of certifier			29c. Licens		- I	9d. Date signed (Mo	
-	1,		30. Name and address of person who		23a) /Tuna	Print)	3506		जा, में	2005
	Μ		DENNIS .H , OI	DIE, 9106 P	H16	DELIVIA	RD So	41E 20	o Bac	10. MD21237
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 9 200	completed cause of death (Item	ture	sele)				
			OL: OU LO		-/-					

		1	State of Maryland / Department of He 1- For State Registrar Certificate of D		tal Hygiene	71115 745117
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last) ROSA SESSON	l N	Pate of Death Month Day	Yeer 3. Time of Death 2.05 2055 2.05 A.M
	Examin		4a. Fecility Name (If not institution, give street and number) NOVTHWEST HOSPITAL 4b. City, Town, or Randa	Location of Death	4c.	Baltimore
	Funeral Director		5. Social Security Number 237.24.6830 6. Sex 1 M 2MF 7. Age (In yrs. last birthday) Nonths Days	Hours Min. 8. D	Pate of Birth Month, Day, Year)	9. Birthplace (State or Foreign Country)
	Maryland f show		Usuel Residence of Decedent 10a. State 10b. County N/A 10c. City, Town or Location Baltmore)		10d. Inside City Limits 1 ½ Yes 2 ☐ No
	a or 28a-	Funeral Director	10e. Street and Number 10f. Zip Code	1213	10g. Citi	izen of What Country?
9	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or itams 23a or 28a-f show event, the Madical Examinating that be notified at		1 Never Married 2 Married 1 Yes 2 No	spanic Origin? (Specify n, Mexican, Puerto Rican Specify:		14. Race - American Indian, Black, White, etc. Specify: 13 I ack
Maryland 21215-0036	"natural",	leted by	3 ★ Nidowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupa (Give kind of work done diffe. DO NOT use retired)	luring most of working	16b. Ki	ind of Business/Industry
d 212	e filed within al Hygiene. I other then " vent, It's Mas	e Completed	Elementary/Secondary (0-12) 7th, grade 17. Father's Name (First, Middle, Last)		st, Middle, Maiden	ry Cleaning
arylan	2 should be and Mental is marked of eumatic eve	To Be	Tohn Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street a		ute Namber, City o	or Town, State, Zip Code)
	1 and 1ealth 9m 27 ther tr		20a. Method of Disposition 20b. Place of Disposition (Name of cametery crematory or other place)	ere Ave.	1pt . TB	Palts MD 21215 ocation - City or Town, State
Baltimore,	permit. Pages Department of the Importent: If Ite any injury or of		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signator of Funeral Service Licensee 22. Name and Address			ices Milb, MD
8	89 = 88		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Due to (or as a consequence of):		ITH MAF	aken edema .
		nlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	* ALTH		
8760,	death certificate be executed e attending physician and od for use as the burial-transit	al Examin	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
9	artificate I ing physi e as the b	Medic	IF FEMALE:			
.O. Box	he death certific the attending pl ched for use as t	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1			23d. Date of delivery Month Day Year
<u> </u>	The law requires that the de tte has been signed by the a bage 2 should be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I.	23e. Did tobacco	use contribute to the cause of death?
Vital Records,	The law require cate has been sin page 2 should b	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No
ital		Be C	25. Was case referred to medical	26. Place of Death (Cl		
of V	hys his	P	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	4 Nursing Home	5 Residence	6 Other (Specify)
ouo	ding F h. After funera	tlon:	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury 1 Natural 5 Pending (Month, Day Year) Injury World 1 1 Natural investigation	yat k? Yes 2 □ No	Describe now inju	ny occurred
Division	ol or Attending P efter death. I Director: After t d in by the funera	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f.	Location (Street as City or Town, State	nd Number or Rural Route Number, e)
	To the Hospitel or Attending within 24 hours efter death. To the Funerel Director: After completely filled in by the funer	edical C		ne, date and place, and pinion, death occurred a	it the time, date an	nd place, and due to the cause(s)
)	To t withi To t	M	29b. Signature and title of certifier Melta M.D. 29c. Licenson	041410.	Septo	ate signed (Month, Day, Year)
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			. 00
	Sta Regist		31. Date filed (Month, Day Yaar) 0 9 2005 Register's Signature	STUWN M	a)	1 33 ,

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 1 - For State Registrar 29503 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Murtle Month Day Physician Shirk 3, 2005 17:55 PM otember /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Bayview Medical Center
6. Sex 7. Age (In yrs. last birth Baltimore Johns Hookins If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) Min Days Months Hours 1 □ M 2 🖾 F 85 Director 178-14-3455 March 2,1920 Pennsylvania Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show The Medical Examiner must be notified at 1 ☐ Yes 2 ☒ No Dundalk Director Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code filed within 72 hours after death with 21222 7868 Harold Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify Completed by 3 Widowed 4 □ Divorced White 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) Laborer Nelson Company 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H sant: If item 27 is marked other Be Bessie E. Dieffenbach Sidney L. Warner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7868 Harold Road Dundalk, Maryland 21222 19a. Informant's Name/Relationship (Type, Print) 7868 Harold Road Beverly Clark (Daughter) or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any njury or once. Baltimore, Maryland 9/7/2005 த ⊡ Other (Specify) Oak Lawn Cemetery ° 4 ☐ Donation 21. Signature of Funeral Service Sicentee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Approximate Interval Between Onset and Death Part. Enter the disease, or complications that caused to death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical (or as a consequence of) Examiner andida Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last unnar Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit the attending physicien and Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760: Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 🗆 Unknown been signed by should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 📈 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has page 2 autopsy this certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Director: After 5 Pending 1 Natural investigation 1 ☐ Yes 2 ☐ No death filled in by the 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins Bayview 4940 Eastern Avenue. Christine Lee 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 0 9 2005 Registrar

			1- For State of Maryland / Department / Department / Department / Department / Department / Depa	artment of Health and Me rtificate of Death	ntal Hygiene	
ı	Physici /Medi		Decedent's Name (First, Middle, Last) RITA		Date of Death Month Da	y Year 22.02 M
	Examir Funeral		4a. Facility Name (If not institution, give street and number) The John's Hopkins Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death A A A A A A A A A A A A A A A A A A A	Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
	Director		Usuel Residence of Decedent		11/27/19	45 Conneticut
	death with the Maryland ms 23a or 28e-f show f.reatt be reallised at	Director	YORK	ters	100 6	1 ☐ Yes 2 No
	with 1		50 Red Barberry Drive	17319	Tog. Cil	U.S.A.
	ns 23	era			fv Yes or No-	14. Race - American Indian,
020	be filed within 72 hours after death with the Marylan Ital Hygiene of other than "natural", or items 23a or 28e-f show event, the Medical Exercitive mast be rutilised at	by Funeral	1 Never Married 2 Married 1 Tyes 2 No	Was Decedent of Hispanic Origin? (Specif If Yes, specify Cuban, Mexican, Puerto Ric 1 ☐ Yes 2 Ø No Specify:	can, etc.)	Black, White, etc. Specify: White
213-0030	be filed within 72 hours after tral Hygiene. Ind other than "natural", or its event, the Medical Exertime.	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. K	ind of Business/Industry
7	e filed within al Hygiene. I other than " vent, the Ne	Com	12 College (1-40154)	elivery Driver		Floral
and	ild be file lental Hy 'ked oth	To Be C	17. Father's Name (First, Middle, Last) Arnold Lawson	18. Mother's Name (I	First, Middle, Maider n McDonale	
Mary	s 1 and 2 should be f Health and Mental item 27 is marked other traumatic ev			ng Address (Street and Number or Rural F ed Barberry Drive		
nore,	ages 1 and int of Health It: If item 27		1 Durial 2 Uremation 3 MHemoval from State	sition (Name of natory or other place) Green Mem.Pk 9/12/		ocation - City or Town, State
panimor	permit. Pages 1 and Department of Healt Importent: If item 2 any injury or other 2005.		21. Signature of Euneral Service Licenses 2	Name and Address of Facility Witz	ke Funera	l Home of Catons-
ľ			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. SEPSIS (IMALTERE Due to (or as a consequence of):	mia è Funciemia)		- I week
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) b. AUUTE REMARKED FWH Due to (or as a consequence of): (#FPATI/ REMARKED THE PATI/ REMARKED	URE		Iweeli
,00,	The law requires that the death certificate be executed ite has been signed by the attending physician and page 2 should be detached for use as the burial-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. !HEPATIC RENM F Due to (or as a consequence of):	ALLIRE		Zmanths.
700 YO	certificate ding physes as the	/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	in the past 12 months? 1 Live birth 2 Fetal death 3	Ectopic pregnancy Other (specify)		Month Day Year
ords, r	quires that en signed b	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		use contribute to the cause of death? No 3 Probably 4 Unknown
ושפרו	hysician: The law re his certificate has be I director, page 2 sho	Completed			24a. Was an autopsy performed? 1 ☐ Yes 2☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
		Bec	25. Was case referred to medical examiner?	26. Place of Death (0		
	To the Hospital or Attending Physician: with 24 hours after death and the Fundal for the Fundral Director. After this certific completely filled in by the funeral director,	은	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien 27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at 28c Work?	5 ☐ Residence d. Describe how injur	Other (Specify) Hospital y occurred
DIVIDIC	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No eet, factory, office 28f	f. Location (Street an City or Town, State	d Number or Rural Route Number,)
	Mospital 24 hours Funeral etely filled	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death of the basis of examination and/or in and manner stated.	n occurred at the time, date and place, and vestigation, in my opinion, death occurred	d due to the cause(s at the time, date and	and manner as stated. d place, and due to the cause(s)
	To the within To the	Me	29b. Signature and title of partifler	29c. License number	29d. Da	te signed (Month, Day, Year)
	1		30. Name and address of person who completed cause of death (Item 23a) (Type,	RES -000	Sept	ember 7,2005
	10		NAUDIA H. LAWDER THE JOHNS HERIUMS HOSE		re tikeet. Pi	ACTIMORE MARYUMO EIZE
4	Sta Registr		31. Date filed (North Pay Year) 2005 Registrar's Signature		-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

384/9-9-05 vt
State of Maryland / Department of Health and Mental Hygiene 2005 29505 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1410 JACOB SAN DLER SEPTEMBER 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** NORTHWEST HOSPITAL RAN DALL STOWN BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 01/10/1923 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral Hours Days 82 1 X M 2 ☐ F 219-80-8809 LATVIA Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location traumatic avent, the Medical Examiner must be nighting at 1 Yes 2 □ No N/A BALTIMORE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 3601 FORDS LANE #308 21215 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after a and Mental Hygiene. Is marked other than "natural" or her 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: Specify: WHITE 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) AUTOMOBILE MECHANIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) UNOBTAINABLE SANDLER HANNA ISAACS ISAAC 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rr any injury or other traum once. 2503 APACHE CIRCLE - BALTIMORE, MD 21209 MICHAEL KAGAN / 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State RADOMER VEREIN 09/08/2005 ROSEDALE, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardiopulmonary 5 hours resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Physician/Medical Examiner The law requires that the death certificate be executed Clostr the burial-tran devin attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform 2.XNo 1 Yes or Attending Physician; director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 XVo 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Diractor: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D005 9736 2005 mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEBORAH NURTH WEST ROAD HOSPITAL 5401 WATSON 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 9 2005

		For State Registrar	State of M	larylan	d / Depa	artment rtificate	of H	ealth a	ind M	ental Hyg	giene Reg. No.2	005	29507
3 1 3		1. Decedent's Name (First, Middle,	Last)							2. Date of Dea Month		Year	3. Time of Death
Physicia /Medic		Alma	Thomas							Septemb			10:00pM
Examin		4a. Facility Name (If not institution,		r)		4b. City, To		Location o	f Death			unty of Death	
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Funeral Director		216-22 - 1119	1 M 2 F	92	Yrs.		Days	Hours	Min.	8. Date of Birth (Month, Day July 10	/, Yea <i>r)</i> 1 _ 1 9 1	Cour	lace (State or Foreign try) Jinia
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irylan show		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	0d. Inside City Limits
8a-f	octo		George's	La	urel								Yes 2 No
with the	10	10e. Street and Number				10f. Zip C						n of What Cour	try?
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fter d	Fun	1 Never Married 2 Married	Armed Forces	£2,		t Yes, specify	y Cuba	n, Mexican	Puerto	Rican, etc.)		Black, White,	
O36	by	3√XWidowed 4 □ Divorced	If Yes, Give Year or Dates	:		1⊡ Yes 2X	Ç X No	Specify:			Sp	pecify: Wh	ite
21215-0036 d within 72 hours after deeth with the Maryland gjene. er than "natural", or Iteme 23a or 28a-f show it the Medical Examinat must be notified at	Be Completed by Funeral Director	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced	dent's Usual kind of work DO NOT use	Occupa done d	ation during most	of worki	ng	16b. Kind	of Business/Inc	dustry
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Mand 2 and 2 alth a alth a ler tra		Joseph Thomas /	son		16202	Laure	el R	lidge	Driv	e Laur	el, N	Marylan	d 20707
of He		20a. Method of Disposition XXBurial 2 ☐ Cremation 3	□ Removal from Stat	1 ~	lace of Dispo emetery, crer	sition (Name natory or oth	of er place	θ)	D	ate	20c. Loca	tion - City or To	wn, State
Pag ment ment tant:		4 Donation 5 Other (Spe		Iv	y Hill					2005		cel, Ma	ryland
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Funaral Service Lie		M0077	0	Donald 313 Ta	Addres ISON 1bo	s of Facility Fune ott Av	ral enue	Home, I	∘.A. ≥1, Ma	ryland	20707
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/ /Medical Examiner		resulting in death)	Due to (or a	is a consequ	uence of):								
	-	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	is a consequ	uence offi.								
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760, Ke ba exacuted spicion and le buriat-transit	Examiner	resulting in death) Last	C. Due to (or a	s a consequ	uence of):								
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Box eath cert attendin for use	lan/	23b. Was decedent pregnant	23c. If yes, outcom	2 Fetal	Ideath 3□	Ectopic preg					230	 Date of deliver Month 	ory Day Year
P.O. hat the de de by the a letached	ysic	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown	at time of de	eath 5L	Other (spec	спу)						
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Div	Certification:	4 Homicide determine	building, e	etc. (Specify	1)	ooi, iaoioiy, i	0.1100			City or Tow			
	edical	29a. Certifier (Check only one) Certifying 2 Medical Ex	Physician: To the best aminer: On the basis and manners	of examinat	wledge, death tion and/or inv	occurred at estigation, in	the tim	e, date and pinion, deat	d place, a	and due to the co	ause(s) an date and pla	d manner as st ace, and due to	ated. the cause(s)
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70		30. Name and address of person wh	completed cause of	death (Item	23a) (Type,	Print) vesle	1	RJ,	lile	n Burne	e, M	my Ind,	21060
Stat Registra		31. Date filed (Month, Day, Fear) SEP 0 9	2005 32. Brois	trar's Signa	ture	and I							

ORIGINAL

			1 - For State Registrar	State of Maryland	I / Departme	nt of Health and I	Mental Hygie		29508
A	Physici /Medi Examir Funeral Director	cal	1. Decadent's Name (First, Middle, Last, 1. Decadent's Name (First, Middle, Last, 4a. Facility Name (If,not institution, give 4. Facility Name (If,not institution, give 5. Social Security Number 214-18-0274	Street and number) EATH CA	RE B	Town, or Location of Death ATTIMOR St 1 Year If Under 24 Hrs. Days Hours Min.	2. Date of Death Month	Day Year 4c. County of Death	3. Time of Death 1 0 0 p M ace (State or Foreign A) AROLINA
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic event, it a Mudical Event her must be notified as once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10e. Street and Number 11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest graded) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Lasted) 19a. Informant's Name/Relationship (Tyles) 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signific Funeral Service Excenses	AZ. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 DMo If Yes, Give Year or Dates: cation e completed) College (1-4or 5+) Zob. Platemoval from State College Removal from	13. Was Decill Yes, sp 1 ☐ Yes 16a. Decedent's Us (Give kind of wife. DO NOT) 19b. Mailing Address 19b. Mailing Address 22. Name a 23. Name a	ual Occupation ork done during most of work use retired) 18. Mother's Nar use (Street an Nutriber or Ru ame of other plage) All Address of Facility	pecify Yes or No- to Rican, etc.) Trking 16t Trking The (First, Middle, Main Jural Rout, Number, Co.) Date 21c A. A	Citizen of What Count A Race - America Black, White, e Specify: B A Kind ol Business/Ind A CRAA A	an Indian, atc. ACK Justry Trom A L Code) 21.213
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dent's Name (First, Middle, L Matthew		Corun	cate of L	Death		Reg. No2 (105	29509
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ital Status	12 Was Decedent Ever in U	.S. 13. Was		ispanic Origin? (S an, Mexican, Puer	pecify Yes or No		Race - Americal Stack, White,	
Never Married 2 Married	Armed Forces? 1 Yes 2 No If Yes, Give		Yes 2 No	Specify:	to Thoair, etc.,			
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ner's Name (First, Middle, La	ist)			18. Mother's Na	me (First, Middle	, Maiden Sun	name)	
teve Thomas	3			Susan	Beth C	ohen		
formant's Name/Relationship	(Type, Print)	19b. Mailing A	ddress (Street	and Number or R	ural Route Numb	er, City or To	wn, State, Zij	Code)
ve Thomas ((father)			Meadow	Dr. R	eiste	rstow	mMd2113
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_	nature and title of certifier	gnature and title of certifier	gnature and title of certifier	pnature and title of certifier 29c. Licer	pnature and title of certifier 29c. License number + 252-34 2-	pnature and title of certifier 29c. License number AP232-34 2-230	pnature and title of certifier 29d. Date s AP 282-34 2-730 8/-	201 200 100 100 100 100 100 100 100 100

State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 40pm 10m95 elmar $^{\circ}$ 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** are uture Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 01-27-1917 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 217-07-2739 1 ☐ M 2 💢 F Yrs. Maryland Director Usual Residence of Decedent death with the Maryland 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show the Medical Examinar must be notified at 1 XYes 2 No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? IISA 751 W. Saratoga Street 21201 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status e filed within 72 hours after dail Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify 3 ⅓Widowed 4 □Divorced Rlack Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wit Department of Health and Mental Hygient Important: If Itam 27 is marked other the approximation of the traumatic event. Italian 2005. Domestic Homes 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daisy Spriggs Thomas Simms ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Goldie Hawkins/ Daughter 751 W. Saratoga Street Apt 420 Baltimore, MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ⅓ Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Veteran 09-15-05 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor St. Baltimore, MD21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ardioVaseu Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physician and I for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Day 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 211No 2 No 1 Tes or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 1 ☐ Yes 2 🗙 No ů 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) s after deam. this 27. Manner of Leath 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in tix Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Masem matun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MACEM 31. Date filed (Month, Day, Year) 82. Registrar's Signature State SEP 0 9 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 1 1 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 31. 11:00 a M SARAH WISE 08-05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Franklin Square hosedale Baltimore Hospital Center If Under 24 Hrs. If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min 1 M 2 F 220 22 5060 Director OCT, 30, 1927 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28e-f show the Medical Examiner must be notified at _ Yes 2 No Director BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Items 23a 21206 U.S. OF 25 BOYMAN COURT Α. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married SpeckLACK 1 ☐ Yes 2 No Specify: "natural", or 3€ Widowed 4 □ Divorced þ Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade com completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other then 'rr any hjury or other treumstic event, the Med ans. HOME College (1-4or 5+) Elementary/Secondary (0-12) 10TH NURSING ASSISTANT KESWICK NURSING 17. Father's Name (First, Middle, Last) JEWELL ODOMS MADORA GALLMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) SANDRA WISE (DAUGHTER) 1526 BURNWOOD ROAD BALTIMORE, MD. 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State KING MEMORIAL PARK 9/7/05 BALTIMORE, MARYLAND 21. Signature of Meral Service Lice WIS LEWIS T, GWYNN FUNERAL HOME 21215 -6393 4517 PARK HEIGHTS AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bronchogenic Cancer Physician Metastatic Wee KS disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Stage nd Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): Physician/Medical as the IF FEMALE: 950 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year ğ Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 90 3 ☐ Probably 4 ☐ binknown 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate 1 Yes 2 DNo 25. Was case referred to medical examiner? 8 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 10 1-2 Inpatient 3□ DOA After th 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier

To the Hospital or Attanding Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, cate hes been signated by page 2 should b s after death.

I Director: Af
d in by the fur within 24 hours after To the Funerel Dire

with the Maryland

Maryland 21215-0036

State Registrar 29b. Signature and title

completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who 9000 Franklin Square Drive Baltimore, Md 21237 eun9 31. Date filed (Month, Day, Year) strar's Signature SEP 0 9 2005

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

The law requires that the death certificate be executed transit and the attending physician ō detached signed by pe peen has page 2 Physician: filled in by the funeral director. this After or Attending Director:

Physician

/Medical

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Certification: To

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item 27 is marked other than "natural", or Items 23a or 28a-f show other treumstic event, it a Modical Expenditor must be notified at

and Mental Hygiene.

permit. Peges 1 end 2 should be file Department of Health and Mental Hy, important: if item 27 is marked other any injury or other treumatic event, once.

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Baltimore, Maryland 21215-0036

Hospitai within 24 hours e To the Funeral C completely カイト

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25. Was Lase referred to medical examinar? 1 Tyes 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number MD 8422470 8131105 cause of death (Item 23a) (Type, Print) 30. Name and address of person Henue SEP 9 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

		1	For State Registrar	State of Marylar	nd / Depa	artment of Healt rtificate of Dea				005	29513
. 3	Physici /Medic		Decedent's Name (First, Middle, La Oreida	White			2	Date of Dea Month	Day	Year 05	3. Time of Death 11:40A M
(B)	Examin Funeral		4a. Facility Name (If not institution, given Prince George s. S. Social Security Number 6. S.	Hospital Cente	er . last birthday) Yrs.	4b. City, Town, or Local Cheverly If Under 1 Year If Under 1 Months Days Hor		Date of Birth	Prin		lace (State or Foreign try)
ė.	Director		577-24-5672 Usual Residence of Decedent 10a. State 10b. County	88	ity, Town or Lo	ocation		12 15	16	Alab	ama Od. Inside City Limits 1√2 Yes 2 □ No
	with the Ma 3e or 28a-f a	Funeral Director	MD Prince (10e. Street and Number 6905 Fawncrest I		apitol	Heights 10f. Zip Code 20743		1	I0g. Citizen	of What Coun	24
36	hours after death with the Maryland tural; or Items 23e or 28s-1 show at Examinat Items to Items at	by Funera	11. Marital Status 1 □ Never Married 2 □ Married 3 ★ Widowed 4 □ Divorced	12. Was Decedent Ever in the Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispani If Yes, specify Cuban, Me	ic Origin? (Speci exican, Puerto Ri ecity:	fy Yes or No- can, etc.)	14.	Race - Americ Black, White, ecify: Blac	etc.
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	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic as anges.		19a. Informant's Name/Relationship (William C. Whit 20a. Method of Disposition	e/Son 20b.	6905	ng Address (Street and N Fawncrest Di osition (Name of matory or other place)		ol Hei	ghts,		0743
Baltimore,	ermit. Page bepartment o nportant: If ny injury or nce.		1 🖺 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice	(y) Fo	ort Lin	coln Cem. 2. Name and Address of F 217 9th. St.		shall'	s Fun		ome
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		ite_	30. Name and address of person who Dr. K. Michael 31. Date filed (Month, Day, Year)	Figard, M.D.	2001	Hospital Dr	ive Chev	verly,	MD. 2	0785	
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			1 - For State Registrar	State of Ma	aryland		rtment tificate			and M	-	giene , Reg. No.	2005	5 295	514
			1. Decedent's Name (First, Middle, L	ast)							2. Date of De Month	ath Day	Year	3. Time of D	eath
	Physici /Medio		Gerald Kennet	h White							Septem			11:30	OA ^M
	Examin		4a. Facility Name (If not institution, gi	ive street and number)			4b. City,	Town, or	Location o	of Death		4c. Co	unty of Deat	h	
			10262 Arizona					these					ntgome		
	Funeral		,	Sex 7. Age 1.XM 2□F		ast birthday) Yrs.	If Under Months	1 Year Days	If Under:	Min.	8. Date of Bir (Month, Da May 6,	h y, Year)	CO	hplace (State or F untry)	
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	and w		10a. State 10b. County		10c. City,	, Town or Lo	cation							10d. Inside City	Limits
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	28a-	Directo	10e. Street and Number	-19	БСС	- Incode	10f. Zip	Code				10g. Citizer	of What Co	untry?	
	3a or	0	10262 Arizona Ci	rcle			208	17				Unite	d Stat	es	
	death me 2	Funeral	11. Marital Status	12. Was Decedent B	Ever in U.S	3. 13. <u>\</u>			spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)		Race - Ame	rican Indian,	
و	after or ite	Ē	1 ☐ Never Married 2 🕅 Married	Armed Forces?	10	ļ	r ves, spec 1 □ Yes 2		Specify:	i, Pueno	Mican, etc.)		Black, White ecity: Whi		
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ä	Z @	Be	Kenneth E. White					-			Theresa				
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	/Medical		disease or condition resulting in death)	a. Due to (or as			LIIOME	1 01	CIIC	TOILE	ue			J Month	
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Ţ.	ding Physician: The law requirea thet the de h. After this certificate has been signed by tha a funeral director, paga 2 should be dateched		Part II. Other significant conditions	contributing to death bu	ut not resul	Iting in the ur	nderlying ca	ause give	n in Part I.		23e. Did t	obacco use	contribute to	the cause of dea	ath?
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5	aftar Dire	Certification;	4 Homicide determined	building, etc	:. (Specify))	. ,				City or To	vn, State)			
	neral		29a. Certifier 1 ☐ Certifying P	hysician: To the best of	of my know	rledge, death	occurred a	at the time	e, date an	d place,	and due to the	cause(s) and	d manner as	stated.	
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1	1		Justine!	17.1	San	mh	D2	22775	5			Septe	mber 6	, 2005	
	30		30. Name and address of person who	completed cause of de	eath (Item	23а) (Туре,	Print)								
			Frederick J. Barr				Aven	ue,	Chevy	y Cha	ase, MD	. 2081	.5		
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signati	ure		4							
	Registr	ar	SEP 0 9:	2005 Jakes	RI K	To All									

			for Stata Ragistrar	. 104	Sta	te of Ma	arylan	d / De _l	oartmen e <i>rtificat</i>	t of H e of I	lealth Death	and M	lental Hy	giene 2	005	29	515
	Physici		1. Decedent's Name Xiao Li										2. Date of De Month Septen	ath Day ber 6,	Year 2005	3. Time of 1:15	
	/Medic Examin		4a. Facility Name (If			nd number)			4b. City,	Town, or	r Location	of Death			nty of Death		
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	Funeral Director		5. Social Security Non Na Na Usual Residence of		6. Sex 1 ☐ M 2		66 (In yrs.	last birthda Yrs.	Months	Days	If Under Hours	Min.	8. Date of Bin (Month, Da MAR 19	y, Year)	9. Birthp Cour Ch	lace (State o itry) ina	r Foreign
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al Records,	: The law requires that the cate has been signed by th page 2 should be detache	Completed	Resp	eigh	my t	Fail	in	2					24a. Was autop perfo 1 \(\text{Yes}		death?	psy findings ampletion of ca	available ause of
Vital	Phyaiclan: Th this certificate ral director, pag	Be	25. Was case referr examiner?		Hospital			50/0		Oth			(Check only o		211		
of	fune fune	tlon: To	1 Yes 2 27. Manner of Death 1 Natural 2 Accident			Date of Inju (Month, Da	ITV	28b. Time Injur	_	28c. Injun World	4 🗀 14		me 5 Residente l			/)	
Division	al or Attanding after death. I Diractor: After d in by the fune	Certification;	3 Suicide 4 Homicide	6 Could n determine		Place of Inj building, et	ury - At ho c. <i>(Specif</i>)	ome, farm,	street, factor	y, office			28f. Location (: City or To		mber or Rura	l Route Num	ber,
	To tha Hospital or Attand within 24 hours after death To the Funaral Director: completely filled in by the	Medical C	29a. Certifier (Check only one)		xaminar: Or		f examina						and due to the ed at the time,)
	To the Comp	M	29b. Signature and	title of certifier	ells	clus	us	λ			e number	18		29d. Date sig			
	φ		30. Name and addre	ess of person v	who complete	Wal	X	1 23а (Тур	e, Print) 5569	W.	Ch	ade	st.S	vite	5017	NO	n
1	Sta Registr		31. Date filed (Mont		005	32 Registr	ar's Signa		ade								

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician SCONSON september 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE Hopkinis BEYVIEW If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months M Director 058-20-0459 192 Sual MACH MANA Usual Residence of Decedent 106. Prince Georges 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Madical Examiner must be notified at Yes 2 No MD Director PORTHEAD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ŏ 20 USA or Itams 23a JAMU. SUIS by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑Yes 2 ☐ No 1 9 4 3 If Yes, Give Year or Dates: 1 9 4 6 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: AFRICAN AMERICAN) Specify: 3 Widowed 4 Divorced 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Private Construction Depertment of Health and Mental Hygi Important: If Itam 27 is marked other any Injury or other traumatic svent, a once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Bronson A. Bell Sr. Hattie Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3051 Brinkley Road Temple Hills, Md. 20748 Phyllis Meekins/daughter r Temple Hills , 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cem. 9/8/05 Cheltenham, Md 21. Signature of Funeral Service Liceosee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland Md.20746 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** LEREVERSIBLE HYPOTENS ION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SHOCK W/ HYPOXIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed di that initiated events resulting in death) Last Due to (or as a consequence of physician Physician/Medical the attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown instravascolar Completed 24b. Were autopsy findings available prior to completion of cause of death? KETROPERITONED 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 🔯 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA this s after death.
I Dirsctor: After this of in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Funaral Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License number SEPTEMBER 2,2005 RES - T who completed cause of death (Item 23a) (Type, Print)

1911

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records,

State Registrar Christo Pher Sc 31. Date filed (Month, Day, Year) SEP 1 2 2005

Sciortino MD PHD

32. Registrar's Signature

600 North Wolfe Street Balto, UN 21281

		-	For State	State of Ma	aryland / Depa <i>Ce</i>	artment of F		lental Hygie Reg.	/ / / / /	29517
			Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physicia		John R. But	ler				August	29, 2005	5 5:20P M
ž.	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)			r Location of Death		4c. County of Death	
			Futurecare Pine				linton		Prince (
	uneral		5. Social Security Number 6. Sex	7. Age M 2□F	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye June 7.	ear) Cou	place (State or Foreign ntry) ash., DC
	Director	-	214-28-9345 Superior Street St		76 Yrs.			June 7,	1929 W	asii.,DC
yland	WO!		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
Mar	a-f al	ctor	DC		Washin	gton				1 Yes 2 □ No
ith th	or 28	Olre	10e. Street and Number			10f. Zip Code			Citizen of What Cou	
w ctte	23	Funeral Director	2920 Southern A	Ave., SE		Was Dasadast of L	fispanic Origin? (Sp		nited St	
ter de	item	nue	11. Marital Status 1 □ Never Married 2 ☑ Married	Armed Forces?		If Yes, specify Cubi	an, Mexican, Puerto	Rican, etc.)	Black, White	
5-0036 72 hours after deeth with the Maryland	"natural", or itema 23a or 28a-1 show edical Examinar must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 21 No	Specify:		Specify: B1	ack
2 P	Jical	eted	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	dent's Usual Occup	during most of work	ring 16t	o. Kind of Business/fr	ndustry
-215	han.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	DO NOT use retired	d)		rivate	
N p	Hygie other t	e Co	17. Father's Name (First, Middle, Last)		26	eaman	18. Mother's Nam	e (First, Middle, Mai		
S 3	d d	o Be	John J. Butler				Hannah	Carroll	_	
ary shou	Ith and Men 27 is marke traumatic	-	19a. Informant's Name/Relationship (Type	рө, Print)	19b. Maili	ng Address (Street	and Number or Rui	ral Route Number, Co	ity or Town, State, Zi	ip Code)
	n 27 I	1	Estelle Washing	ton/daug	ghter Te	emple Hi	Moritz IIs, Ma	ryland	20748	
altimore,	or other		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ P	lemoval from State	20b. Place of Dispo cemetery, cre				c. Location - City or T	
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Ba Ba	Department Importent: It any Injury o		21. Signature of Funeral Service Licens	duna	4					Md.20746
	-549		23a. Pag. Enter the disease, or compli	ications that caused	the death. Do not en					Approximate Interval Between
Ph	ysician		shock, or heart failure. List only or Immediate Cause (Final	De id	iontia o	F Alz	herrer	's disea	esc	Onset and Death
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xecut	al-trar	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequence of):	300				1 39(000)
ox 68760, certificate be executed	hysicien and the burial-transit	calE	Į,	d						
68 tificat	ng ph) as th		15.5511.11.5							
Box	attending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	⊒Ectopic pregnanc	у		23d. Date of deli-	very Day Year
. 8	by the a tached fo	Physician/Med	1 Yes 2 No 9 Unknown	4 Pregnant at 9 Unknown	time of death 5	Other (specify) _				
o ta	signed by be detac		Part II. Other significant conditions con	ntributing to death b	ut not resulting in the	underlying cause gr	ven in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ecords,	been sigr should be	ed by						1 🗆 Yes	2 No 3 Pro	obabiy 4 🗆 Unknown
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e e	P 9	mo:						performe	d? death? No 1 ☐ Yes	_
Vital vician:	certificate rector. pag	Be (25. Was case referred to medical examiner?					th (Check only one)		
	this al dil	2	1 Yes 2 No	Hospital: 1 ☐ Inpatie		III 3 DOX		ome 5 Residence		city)
On ding	h. After funer	tlon	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year) Injury	Wo	rk?]Yes 2 □No	204. 2030/100 /104	injury coodined	ļ.
Division of Vita	er death. rector: A by the fu	ifica	3 Suicide 6 Could not be determined		ury - At home, farm, si	reet, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru	ral Route Number,
tel o	s afte el Dir ed in I	Certification:	4 Hornicide	building, et	c. (Specify)			Oily or Town, c	лагој	
To the Hospitel	within 24 hours after deatl To the Funerel Director: completely filled in by the	edical		ner: On the basis o	of my knowledge, dea of examination and/or is					
o the	o the	Med	29b. Signature and title of certifier	and manner st	ated.	29c. Licen	se number	29d	. Date signed (Month	n. Day, Ygar)
) -	> - 0		Main 6 les	empul.	0 4	104	2649	Se	ptember	8 7 2005
	7		30. Name and address of person who co	emplete cause of c		Print)	Upper	- Man	lbovo v	un 20772
	Sta Regist		31. Date filed (Monty Car Vear)	005 32. R	ar's Signature	Ball o				

State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death Reg. No. 2. Date of Death . Decedent's Name (First, Middle, Last) September 3 2005 **Physician** Fred Lee Ballard /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lanham Doctors Hospital Prince George's Date of Birth (Month, Day, Year)
July 3, 1948 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country)
Ohio 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 577 66 9093 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or iteme 23s or 28s-f ehow the Medical Examinat he notified at 1 □Yes 2 No Director Marvland Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20706 6702 94th Ave United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 27 No If Yes, Give 11 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married Married Specif African American Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) (Public Works) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Government 11th D.C. Government permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg important: if item 27 is marked other eny injury or other traumatic event, if 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wallace Ballard , Sr. Isadore McNeil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6702 94th Ave, Lanham, MD 20706 Carolyn Nelson Ballard (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) September 10 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2005 Lee Crematory Clinton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 01d Alexandria Ferry Rd, Clinton, MD M01437 thins that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Parl 1. Enter the disease, or comp shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** RESPIRATORY FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (unas a consequence of) Examiner burial-transit pue that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physicien Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day 5 in the past 12 months? Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HEPATIC CANCER 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) HOSpITAL 1 ☐ Yes 2 🔽 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 TSuicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number. City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0062823 September 3, 2005 30. Name and address of person who completed cause of eath (Item 23a) (Type, Print) DOCTORS COMMUNITY HOSPITAC, LANHAM, MD 3070 KAMILAH M KELLY 8118 31. Date filed (Month, Day, Year) ...32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Sallard, Free

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Sept 5, Francine Mallory Brown 2005 9:23 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Southern Maryland Hospital Clinton. Prince George's If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1□M 2ᡚF 59 223 64 1420 Director Aug 23, 1946 Washington Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County Show Itam 27 is marked other than "natural" or Itama 23a or 28a-f show other traumatic evant, the Medical Exertiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Prince George's Fort Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4603 Jean Marie Drive 20744 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural; or Ital any injury or other traumatic event. It is marken 1 ☐ Yes 2, ☐ No If Yes, GiveA X Year or Dates: 1 Never Married 2 Married American 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 3√⊒Widowed 4 □ Divorced þ African Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Benefits Complinice Associate Trade Associate 12 2 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Theodate Mallory George Sullivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric Brown (Son) 4603 Jean Marie Drive, Fort Washington, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Lee Crematory Sept 12, 2005 4 ☐ Donation 5 ☐ Other (Specify) Clinton, MD 22. Name and Address of Facility Lee Funeral Home, Inc6633 01d 21. Signature of Funeral Service Licens Alexandira Ferry Rd, Clinton, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) TICEM /Medical Due to (or as a consequence of): **Examiner** ABS CE UNG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day been signed by the atte should be detached for 4□Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ BREAST ANCER 3 Probably 4 Nuknown 1 Yes 2 🗆 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No TNEMIA 24a. Was an page 2 autopsy 212(No certificate 1 ☐ Yes or Attanding Physician: the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 7 1 Tyes this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? 27. Manner of Death Certification: After 1 Natural
2 Accident 5 Pending investigation after death. 1 TYes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Momicide Hospital within 24 hours a To the Funaral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medigal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated tha 29d. Date signed (Mgnth, Day, Year) 29b. Signature and title of c 29c. License number 3885 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CUNTON MD AMMAN VENLA 1 2 501 31. Date filed (Month, Day, Year) 2. Registrar's Signature State SEP1 2 2005 Registrar

Baltimore, N	permit. Pages 1 and
	Pi / E:
P.O. Box 68760, <	hat the death certificate be executed

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200529520 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 10:25 PM **Physician** 2005 September George A. Brooks /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Burnie Baltime Walkington Medical Center G10~ If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 **∃**vM 2 □ F May 12 1933 Maryland Director 218-32-6409 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County il Hygiene. other than "natural", or itema 23a or 28a-f ahow vant, the Medical Examinar must be multified at 1 Tyyes 2 □ No Director Maryland Anne Arundel <u>Annapolis</u> 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21403 USA 1020 Tyler Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black Be Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0 Truck Driver E.L. Gardner 6th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Smallwood Jeremiah C. Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 00 Health a If item 27 is or other tra Rosemary Brooks (Wife) 1020 Tyler Ave. Annapolis, Md. 21403 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Hill Crest Cemetery 9/9/05 Annapolis, Md. 20c. Location - City or Town, State 20a. Method of Disposition ō 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Depertment Important: If any injury o 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Wm. Reese & Sons Mortuary
821 West St. Annapolis, M 21. Signature of Funeral Service Licenses Md. 21401 Larry D. Reese MOOY 8 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) menastatic nysician Lung **Medical** Due to (or as a consequence of): caminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached to ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Attending Physicien: The law requires the Completed by 3 Probably 4 Unknown been significant 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 1 ☐ Yes 2XNo 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Medical Certification: After Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Diractor: 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by after 4 Thomicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DO27415 Sept 3, 2005 m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington Medical Center Baltimore Min Henr 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

2 2005

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Dav Year **Physician** 6:00 AM Drewes Bebko SEPTEMBER Audrey 10, 2005 /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Baltimore Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Y Mar. | 17, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 1 □ M 2 🕅 F Yrs 1920 New Jersev 126-18-3829 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rthen "natural", or iteme 23s or 28s-f ehow the Medical Exercises must be notified at MD Baltimore Phoenix 1 TYes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with USA 42 Club View Lane 21131 death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status hours efter 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry e filed within 72 h al Hygiene. I other then "natu 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 end 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth eny linjury or other traumatic event DDR. Be unknown unknown ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) George T. Bebko / husband 42 Club View Lane; Phoenix, MD 21131 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Hilltop Service Corp. 9/12/05 Towson, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner bSEVERE CHRONIC OBSTRUCTIVE PULMONARY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine signed by the attending physicien and d be detached for use as the burial-transit certificate be executed PNEUMOTHORAX resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 X No 9 Unknown 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 1 Yes 2X No 1 🗌 Yes 2 🗆 No Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: To the Hospital or Attending I within 24 hours effer death.
To the Funeral Director: After Injury 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🛣 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 16th, 2005. Melle mo D 41410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 JOGINDER F. MEHTA M. D. . 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29522 AMEND ITEM #17&18 PER ANA 80 (#1846 9/106#05 JH Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 13:19 September 5, 2005 William P. Carton /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Union MemoriaL Hospital Baltimore
If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ₹M 2 □ F Yrs. 84 Nov 6, 1920 Maryland Director 351-20-2764 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show Examinar mant be notified at 1♥ Yes 2 No MD Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number itame 23a 4000 N. Charles Street #1401 21218 USA Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or item eny injury or other traumatic event, tra Molical Exercises 2005. 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: white þ Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ teacher college 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) unk unk Be ျှ LAWRENCE ROBERTS CARTON ELIZA CREDILLA WHYTE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Antonia Bauer/daughter 769 Red Cedar Road Annapolis, MD 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Ronal d 8 . Wa 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Baltimore, MĎ Rart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypovolenic Due to (or as a consequence of): **Physician** hou /Medical Examiner gastrointestinal Heed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician for use as the burial Box 68760. Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) P.O. 1 Yes 2 No he 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 1 Yes 2 1 No To the Hospitei or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Npatient 1 Yes 25 No 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) uneral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 5 Pending after death.

Director: After in by the fur 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number AT2438946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memorial Hospital Baltimore, Navara Centota

State

Registrar

31. Date filed (Month, Day, Year)

2 2005

32. Hegistrar's Signature

			State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Registrar Registrar
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last) RICHARD 1. CAVANAUGH JR 4a. Fecility Name (If not institution, give street and number) 2000 W. 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death
	Funeral Director		5. Social Security Number 6. Sey 1 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) (Month, Day, Year) (Month, Day, Year) Usual Residence of Decedent
	the Maryland 28e-f show	ector	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 10f. Zip Code 10g. Citizen of What Country?
21215-0036	be filed within 72 hours after death with the Maryland nat Hygiene. Id other than "natural", or Items 23a or 28e-1 show event, I're Medical Examination intelligible.	leted by Funeral Director	1812 W. Pratt Street # 3 11. Marital Status unk 12. Was Decedent Ever in U.S. Amed Forces? unk 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 1812 W. Pratt Street # 3 21223 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Hispanic Origin? (Specify Yes or No-Hispani
and 2121	d be fited within ental Hygiene. ked other than " c event, Ire Max	To Be Completed	Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) Unk unk 18. Mother's Name (First, Middle, Maiden Sumame) unk
Baltimore, Maryland	permit. Pages 1 and 2 should bu Depertment of Health and Menta Important: if item 27 is marked any injury or other treumatic en <u>once.</u>	1	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2000 W. Baltimore Street Baltimore, MD 21223 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Cherry in state
Balt	permit. Depertr Imports any inje	6	22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Pert1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Christian Double Const and Death
8760,	Physician /Medical Examiner bulyaicleu aud silve pnijal-itausit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (one a consequence of): Due to (one a consequence of): Thour.
O. Box 68	ie death certif the attending hed for use a:	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown
ecords, P.	w requires that the been signed by should be detac	þ	Pant. Other significant conditions contributing to death the pot resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available
<u> </u>		Be Completed	autopsy death? 25. Was case referred to medical exeminer? 26. Flace of Death (Check only one)
Division of	tending Phy leath. tor: After this the funeral o	Certification: To	27. Manner of Death Value Specify Specify Specify
DIA	To the Hospitel or Attending Physicien: within 24 hours siter death To the Funeral Director: After this certifical completely filled in by the funeral director.	edical Certif	28e. Place of Injury - At home, farm, street, factory, office determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the within To the comple	Med	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 30. Name and address of serson who complyated cause of death (tem 23a) (Type, Print)
	Sta Registr		H. Neaf Roynobs Ison Secous Hapital of Baltimore 31. Date filed (Month, Day, Year) SEP 1 2 2005 32. Agistrar's Signature

			State Registrar	ate of Maryland / D	epartment of Health and M Certificate of Death	ental Hygie		29524					
	Physici /Medio		1. Decedent's Name (First, Middle, Last) LEE COLE			2. Date of Death Month	Pay 3005	3. Time of Death 10:45 PM					
	Examir Funeral Director		4a. Facility Name (If not institution, give street OHSTAL HOSP ICK 5. Social Security Number 220-56-0169 6. Sex	THE LAKE 7. Age (In yrs. last birth	4b. City, Town, or Location of Death SALISBURY If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye June 22,	4c. County of Death W/COM/(bar) 9. Birthpla Countr 1959	CC ace (State or Foreign y) unk					
	yland now		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location			d. Inside City Limits					
	the Mar 28a-f st notified	rector	MD Worcester 10e. Street and Number		Ocean City	10a.	1 ☐ Yes 2 ♣						
	ath with	rai Di	5 Dayton Lane		21842		USA						
Maryland 2	urs efter de et', or iteme Extendirer o	by Funeral Director	1 Never Married 2 Married 1	as Decedent Ever in U.S. med Forces? Yes 2 No unk res, Give aar or Dates:	 13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2 ☑ No Specify: 	ocify Yes or No- Rican, etc.)	14. Race - America Black, White, et	tc.					
	within 72 hours efter death with the Maryland ene. than 'naturel', or iteme 23e or 28e-1 show I.a Medical Examinar i. ust bu mailfied at	Completed	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12) Counk Unk	oleted) 16a.	Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired)	16b	o. Kind of Business/Indu	ustry unk					
	2 should be filed withln and Mental Hygiene. is marked other than aumatic event, the Ms	To Be Co	17. Father's Name (First, Middle, Last)		painter unk 18. Mother's Name	(First, Middle, Maid	den Sumame)	unk					
	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or iteme 23e or 28e-1 show amount injury or other traumatic event, the Medical Examiner is ust be notified at once.	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Coastal Hospice at the Lake 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City											
Baltimo			1 ☐ Burial 2 ☐ Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify) 1 ☐ 21. St. nature Funeral Service Licensee, Ronald S. Mad	state	22. Name and Address of Facility State Anatomy Boar		Baltimore :	Street					
	Physician /Medical												
	Examiner	ner	Sequentially let conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury										
8760,	cate be executed physician and the burial-transit	dicai Examiner	that initiated events	Due to (or as a consequence of): THEOMISS PHELBITIS.									
.O. Box 6	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	_	23d. Date of delivery Month Day Year								
۵.	w requires that t been signed by should be detai	þ	Part II. Other significant conditions contribut	23e. Did tobacc	pacco use contribute to the cause of death?								
Vital Records,	The law requirate has been page 2 should	Completed				24a. Was an autopsy performed 1 Yes 2	prior to comp death?	sy findings available pletion of cause of					
Division of Vita	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	tion: To Be	1 162 70 140	Check only one Hospital: 1 Alphatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?									
Divisi	el or Attendi s after death. si Director: A sd in by the fu	Certification:	3 Suicide 6 Could not be determined 28	28f. Location (Street City or Town, St	t and Number or Rural i tate)	Poute Number,							
	To the Hospitel within 24 hours To the Funerel completely filled	Medical ((Check only 2 Medical Examiner: C	To the best of my knowledge, in the basis of examination and manner stated.	death occurred at the time, date and place, a for investigation, in my opinion, death occurre	and due to the cause ad at the time, date	e(s) and manner as stat and place, and due to t	led. he cause(s)					
	To th within To th compi	Me	29b. Signature and title of certifier	11000	29c. License number		Date signed (Month, Da	ay, Year)					
			30. Name and a ress of person who complete	ed cause of death (Item 23a) (** LOASTAL	TYTYZSB Type, Print) HOSPICE, _ DEER	ZSHEN	2. CAL	2184					
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 2 2005	32. Figistrar's Signature	HOSPICE, DEERSH	FAD TO	ALD SMELLS	BUR JUND					

State of Maryland / Department of Health and Mental Hygiene, 29525 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Rose Marie Coates September 2005 10:30 % /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Pasadena

| Hunder 1 Year | Hunder 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | May 19 8200 Old Mill Rd. Anne **Arundel** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1940 1 □ M 2 🖾 F 65 Yrs 213-40-7255 Maryland Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28e-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked their then "retural; or Items 23e or 28e-f show any injury or other trenumetic event, he Medical Exercities master retified at 1 Yes 2 □ No Directo Maryland Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 29 W. Washington Street 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 Yes 2 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Housekeeping US Naval Academy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Louise Holland Milton Coates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Johnson (Daughter) 8200 Old Mill Rd. Pasadena, Md. 21122 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cometery, crematory or other place)
Bestgate Memorial
Park 1⊞Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/10/05 Annapolis, Md. 22. Name and Address of Facility Wm. Reese & Sons Mortuary, 821 West St. Annapolis, Md 21. Signature of Funeral Service Licensee H. Teese MOCES Lavry Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the move of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) Physician mo /Medical Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-translt the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ate has been signed by the atte page 2 should be detached for in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ☐ Yes 2☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed? After this certificate has 1 ☐ Yes To the Hospitel or Attending Physiclen: within 24 hours after death.

To the Funarel Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 6 Other (Specify) 1 Tes 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 2 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Distural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year 29b. Signature and title of certifier 29c. License number od cause of death (Item 23a) (Type, Print 30. Name and address of person-32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2 2005

State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death 2 Date of Death Decedent's Name (First, Middle, Last) ^{Da}B, 20185 SEPTEMBER **Physician** Stuart N. Carlisle 11:42A M /Medical 4a. Facility Name (If not institution, give street and number, Saint Joseph Medical 4c. County of Death
Baltimore 4b. City, Town, or Location of Death Examiner Center Towson 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) April 15, 1936 Birthplace (State or Foreign
Country) **Funeral** Days Hours 10 M 2 □ F Maryland Director 219-26**-**5832 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County •how item 27 is marked other then "neturel", or iteme 23s or 28s-1 ebov other treumstic event, the Medical Examiner must be notified at 1 □Yes 2 No MD Baltimore Glen Arm Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21057 USA 4309 Manorwood Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 2 should be tited within 72 hours atter of and Mental Hygiene. 1 ☐ Never Married 2 🕅 Marned 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore. Marvland 21215-0036 1 Yes 2 No White Specify. Specify by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Teacher Education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Violet Weber Nelson Olin Carlisle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 sh Department of Health and Important: If Item 27 is m eny injury or other treum once. Joanne Carlisle/wife 4309 Manorwood Drive, Glen Arm, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 09/10/2005 Hilltop Svc. Corp. Towson, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Pervice Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. S. Coster 1050 York Road, Towson, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ACUTE MYOCARDIAL INFARCTION DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner YEARS CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ettending physicien and tor use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ned by the etter in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 4 Unknown HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of certificate has page 2 prior to c death? 1 X Yes autopsy performed? 2 🗆 No Yes 2 No the Hospitel or Attending Physician: nin 24 hours etter death. the Funeret Director: Atter this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗀 Yes 2 ER/Outpatient 3□ DOA 28a. D te of Injury (Month, Day 27. Manner of Darth 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 Yes 2 No 2 Accident investigation 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide To the Hospital c within 24 hours at To the Funerat D completely filled i cai 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatur And title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 181 2005 D 51852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE TOWSON, MARYLAND 21204 M. D. . 7601 DAVID A. BRINKER. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 200\$ Registrar

			1 - For Stete Registrar	State of Maryland		t of Health and N e of Death	Mental Hygie	E 0 0 ,	5 29527	
	Physici /Medic		1. Decedent's Name (First, Middle, JAMES	ANDREW	D166		2. Date of Death Month SEPTEMEE		3. Time of Death	
	Examin Funeral	er		RIM HOSPITAL 6. Sex / 7. Age (In yrs. las		Town, or Location of Death ACTIMOR 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth	4c. County of Dea	thplace (State or Foreign	
	Director		219 · 28 · 9674 Usual Residence of Decedent 10a. State 10b. County	107M 2□F 72	Yrs. Yrs.	Days Hours Will.	JULY 19,	1933 M	AKY LAND 10d. Inside City Limits	
	the Maryle 28a-f sho	ector	MD 10e. Street and Number	1	ACTIMOR 10f. Zip		100	1 Yes 2 □ No Citizen of What Country?		
	s 23a or	Funeral Director	1720 Home	SEAD AVE		21218		U.S.	A	
9000	be filed within 72 hours after death with the Maryland ital Hygiene. Ad other than "natural", or Items 23a or 28a-f show event, it a Medical Examinational be ricillized at	Completed by Fune	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Forces?	If Yes, spec	lent of Hispanic Origin? (Spirity Cyban, Mexican, Puerto	Rican, etc.)	Black, Whit		
21215-0036	within 72 h ene. than "natu		15. Decedent' (Specify only highest Elementary/Secondary (0-12)		S 4 3	al Occupation rk done during most of work se retired)	king O	b. Kind of Business	/Industry	
	ould be filed within Mental Hygiene. arked other than ' atic event, un Mk	To Be Cor	17. Father's Name (First, Middle, L	ast) DIGGS	SANITAT		e (First, Middle, Mail AGGIE	MINOKE iden Sumame)	CITY	
Baltimore, Maryland	permit. Pages 1 and 2 should bu Department of Health and Menia Importent: If item 27 is marked any injury or other traumatic e once.		19a. Informant's Name/Relationsh ANDRA	ip (Type, Print) ASTON (DING HTEK) 20b. Plac carr AKBL	SUT S ce of Disposition (Nametery, crematory or of	(Street and Number or Rui STATE The of TERY 9.14 d Addr s of Facility	TACOMA, W Date 200 + 05 And COMA	CHSHING R C. Location - City or RBUTUS GREENE	Zip Code) ZN 98405 Town, State MARY LAND FUNERAL HM MO 2/2/2	
8760,	Physician /Medical Examiner and physician sthe purial-transit	lical Examiner	23a. Part1. Enter the diseated or o shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequent of the consequen	noe of): noe of): Cov noe of):		or respiratory arrest,		Approximate Interval Between Onset and Death Onset Approximate Onset	
P.O. Box 6	v requires that the death certific been signed by the attending p should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnanc 1 Live birth 2 Fetal of 4 Pregnant at time of deal		23d. Date of delivery Month Day Year				
	uires that to signed by Id be deta	by	Part II. Other significant condition	ns contributing to death but not resulti	ing in the underlying ca	ause given in Part I.	23e. Did tobac		o the cause of death?	
al Recol	: The law requir cate has been s page 2 should	Completed					24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of	
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as it.	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investiga 3 Suicide 4 Homicide Getermin	ation of being Athem	Other: 4 \(\to\) Nursing Ho 8c. Injury at Work? 1 \(\to\) Yes 2 \(\to\) No	th (Check only one) ome 5 Residence 28d. Describe how i 28f. Location (Stree City or Town, S	njury occurred t and Number or Ri			
-	To the Hospital or Attan within 24 hours effer deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying (Check only one) 1 Medical E	Physician: To the best of my knowle xeminer: On the basis of examination and manner stated.	edge, death occurred in and/or investigation,	at the time, date and place, in my opinion, death occur	and due to the causi red at the time, date	e(s) and manner as and place, and due	s stated. to the cause(s)	
	To t withi To t	Σ	29b. Signature and title of certifier	7		License number	29d.	Date signed (Mont		
Ì	09		30. Name and address of person w	the completed cause of death (Item 2	3a) (Type, Print)	31468 310 Columb	oia, MD 2			
	Sta Registra		31. Date filed (Month, Day, Year)	10340 Swatt Street 32. Agistrar's Signatur 2005	Goode					

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 29528 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Ε. 8, Louis Dolsey Sept. 2005 9:30P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince Georges If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral 1**⊠** M 2□ F Director 224-76-2759 Dec.13, VA Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exam armust be invitified at 1X Yes 2 □ No Director Md. P.G. Camp Springs 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6811 Coolridge Road 20748 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ≥ ZXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Cafeteria Worker Galludet Univ. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fill and Mental H Be Louis E. Dolsey Sr. Rebecca Coles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n any injury or other traun <u>once.</u> 6811 Coolridge Road
Carp Springs, Maryland

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date Veronica Dolsey/sister 20748 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem. 9/16/05 Clinton, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. Janice Edwards per dvr 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final intarction Lys Cardial Physician Unknown disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cardiony natte Makerina Sequentially liet nonditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine be executed burial-transit signed by the attending physician and debt be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Honknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 1 Yes 2 10 Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide ō within 24 hours a
To the Funeral C
completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Rait For 43446 98 01 Georgia Austril 3-41 Silvert poin 20902 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROINTAN FARAUIFAR 31. Date filed (Month, Day, Year) SEP 1 2 2005 32. gistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 29529 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** September 3, 2005 11:20 PM Earnest Dorsey /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Avalon Manor Nursing Home Washington Hagerstown If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ₹M 2 □ F Months Days Hours unk Yrs. 75 **Director** Mar 18, 1930 257-32-4641 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f ehow the Medical Exeminer must be notified at 1 ☐ Yes 2√2 No Washington Hagerstown Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 14014 Marsh Pike 21742 **USA** death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: white þ 3 ☐ Widowed 4 ∑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk unk Elementary/Secondary (0-12) College (1-4or 5+) other than unk unk Ith and Mental Hygie 27 is marked other if traumatic event, II permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event, 90ce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14014 Marsh Pike Hagerstown, MD 21742 Avalon Manor Nursing Home 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 □Donation 5 NOther (Specify) in state S. Wade 21. Signature of Euneral Sirving Ronal A State Anatomy Board 655 W. Baltimore Street man Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or rear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cancer 01 **Physician** /Medical Due to (or as a consequence of) **Examiner** Cr Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed 2 m cm Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 0 9 Unknown Division of Vital Records, P. Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Minknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1☐Yes 2☐No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death, 2 Accident investigation the within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D0060395 09/04/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Court 1126 opal FARID Hagerstown 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 1 2 2005 Registrar

			For State Registrar	ate of Maryland	/ Depa	artment of H	ealth and M Death	ental Hygi	iene 2005	29530
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last) Antoinette	J.	Fr	1 ZZer		2. Date of Death Month		3. Time of Death
	Examir Funeral Director	er	4a. Facility Name (If not institution, give street Chapel Hill Nur 5. Social Security Number 6. Sex 215-03-9033	Sing Conte	t birthday) Yrs.	4b. City, Town, or If Under 1 Year Months Days	Al Stow If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 08-16-	Boulting Year) 9. Birtho Cour	lace (State or Foreign
	Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Carrol1	10c. City, 7	Town or Lo	cation Sykesvil	le		1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	s 23a or 28a	rai Director	10e. Street and Number 6207 Candle Court	0	10.1	10f. Zip Code 217			Og. Citizen of What Cour USA 14. Race - Americ	
9036	ours after de ral', or Item Examena	by Funerai	1 Never Married 2 Married 1 I	as Decedent Ever in U.S. med Forces? Yes 2 Wo Yes, Give A par or Dates:	_ - I	Was Decedent of Hi f Yes, specify Cubar I ☐ Yes 2X No	Specify:	Rican, etc.)	Black, White,	etc.
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23s or 28s-1 show aumatic event, the Madical Examere must be indiffied at	Completed	15. Decedent's Education (Specify only highest grade com, Elementary/Secondary (0·12) 10		(Give life. L	tent's Usual Occupa kind of work done d DO NOT use retired, il Sales	uring most of workin	ng	16b. Kind of Business/In Department	
ryland	0 = 0 %	To Be C	17. Father's Name (First, Middle, Last) Andrew Lombardo 19a. Informant's Name/Relationship (Type, Pr	_	*	:	18. Mother's Name Rosali	e Danto		Code
altimore, Ma	permit. Pages 1 and 2 should b Depertment of Health and Menic Important: If item 27 is marked any injury or other traumatic e 2002.		Mr. John B. Frizzera 20a. Method of Disposition MD Burial 2 Cremation 3 Remov	(Son)	5207 e of Dispo	Candle Co sition (Name of natory or other place Mem. Par	urt Sykes	ville, l		own, State
Baltin permit. Pa Depertmen Important any injury			* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	4	22	HAIGHT FU	s of Facility NERAL HOM	E & CHAI	PEL, PA (Bo)	
8760,	The law requires that the death certificate be executed XB Marks are has been signed by the attending physician and Marks are page 2 should be detached for use as the burial-transit that are page 2.	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or finally that initiated events	List that caused the death. It is on each line. A 1 7 N eir Due to (or as a consequent Due to (or as a consequent Due to (or as a consequent)	nce of):			r respiratory arre	St,	Approximate Interval Between Onset and Death
O. Box 6	at the death certific by the attending p	Completed by Physician/Me	in the past 12 months?	yes, outcome of pregnancy □Live birth 2 □ Fetal de □Pregnant at time of deatl □Unknown	eath 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ary Day Year
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Vital Records,		e Comple	25. Was seen referred to modical				CO. File of Dooth		prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of 2 No
Division of Vit		Certification; To Be	1 Atural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	1 Inpatient 2 EH	VOutpatien Bb. Time of Injury	28c. Injury Work M 1 🗆 Y	at 2 ? es 2 □ No	ne 5 Resider	nce 6 □Other (Specifi w injury occurred eet and Number or Rura	
<u>S</u>	To the Hospital or Attending Ph within 24 hours elter death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 VCertifying Physician (Check only 2 Medical Examinar: O	building, etc. (Specify) To the best of my knowle	edge, death	occurred at the tim	e, date and place, a	City or Town	, State) use(s) and manner as s	tated.
ħ	To the I within 2. To the F complete	Medical	29b. Signature and title of certifier Mark Local 30. Name and address of person who complete	nd manner stated. M. D. ed cause of death (Item 23)	3a) (Type	29c. License	number 058676	25	ed. Date signed (Month,	Day, Year)
	Sta Registr		Karen L. Babitt, M 31. Date filed (Month Day, Year) 2 2005	D. 25 MQ	t2 ni	rect, su	ite 200,	12e'ster	stown, MD	21136

State of Maryland / Department of Health and Mental Hygiene20051 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 5:40 PM 0 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner IMOR If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) f Under 1 Year Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 X F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event. the Medical Examiner must be notified at 1 Yes No **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? ō U.5A or items 23a 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify Be Completed by 3 ☐ Widowed 4 ☑ Divarced "netural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working pile. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) omailER. 17. Father's Name (First, Middle, Last) mil. Peges 1 and 2 should be file pertment of Health and Mental Hypertant: if item 27 is marked oth y injury or other traumatic even 18. Mother's Name (First, Middle, Maiden, Sumame) Yaron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) auchke AWNISE Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenspe Depuil any r romartie 2120 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest back, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** - meelc, /Medical Examiner 05 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physicien: The law requires that the death certificate be executed the burial-transit Physician/Medical for use as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months Month 4□Pregnant at time of death 5 Other (specify) the o. ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaceo use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 DUnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 1 🗌 Yes 1 ☐ Yes 2 □ No 25. Was case referred to medical 26. Place of Death | Check only one examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes L inpatient 2 ER/Outpatient 3 DOA 27. Mann f Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred s after de... ni Director: Alte 1 Natural 5 Pending Injury 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitei o within 24 hours aft To the Funeral Di 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 2005 Registrar

			1 - For State Registrar	State of Maryla	nd / Depa	artment of F	Health a	ınd Me		ene a. No. 200	5 29532	
	Physici		Decedent's Name (First, Middle, La	St)		Fra		-	Date of Death Month	Day Ye	3. Time of Death	
	/Medio		4a. Facility Name (If not institution, given the Johns H	lopkins H	uspital	4b. City, Town, o	altir	f Death からく e	city	4c. County of E None		
ı	Funeral Director			Sex 7. Age (In yr. 12	s. last birthday) Yrs.	Months Days		Min. 3,	Date of Birth Month, Day 1/1968	Year) Vi	Birthplace (State or Foreign Country). rginia	
	show	_	Usual Residence of Decedent 10a. State 10b. County		City, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 No	
	th the M or 28a-f	Director	MD Howard 10e. Street and Number		Columbia	10f. Zip Code			10	g. Citizen of Wha		
36	be filed within 72 hours after deeth with the Maryland stal Hygiene. Id other than "neturel", or items 23a or 28a-f show event, I're Madical Exarterer must be rediffed at	by Funeral	4932-1 Columbia 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Road 12. Was Decedent Ever in Armed Forces? 1		21044 Was Decedent of H If Yes, specify Cub	an, Mexican	gin? (Specif , Puerto Ric	y Yes or No-		American Indian, White, etc.	
21215-0036	filed within 72 hou Hygiene. ther than "neturel int, Its Madical E	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most	of working		6b. Kind of Busin	•	
73	should be filed and Mental Hyglis s marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last David Stakley Fra	,		irst, Middle, M Mary						
Mary	Pages 1 and 2 sent of Health ar ent of Health ar nt: If item 27 is ry or other trau		19a. Informant's Name/Relationship (Jacqueline Frank)			ng Address (Street 2—1 Colum			oute Number,	-	te, Zip Code) 044	
Baltimore,			20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Speci	20b. Removal from State	Place of Dispo	osition (Name of matory or other pla	се)	Date /9/200	2	oc. Location - City	or Town, State	
Balti	permit. P Departm Importer eny injut		21. Signature of Funeral Service Lice	1.10	22	2. Name and Addre	ss of Facility	Harry	H. Wi	tzke's F	amily FH, Inc. y, MD 21043	
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.	a int				espiratory arres		Approximate Interval Between Onset and Death	
	/Medical Examiner hysicien and the burial-transit	_	resulting in death) Sequentially list conditions,	b. Due to (or as a conse		e bleed	ود،	die	thesis	,	2 days	
8760, <		dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Brainsto Due to (or as a conse					6 months			
9	ertificate ling physie as the t	Medic	IF FEMALE:	23c. If yes, outcome of pregi								
O. Box	it the death certific by the attending p tached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown			23d. Date of Month	23d. Date of delivery Month Day Year					
<u>a</u>	ires the signed d be de	by	Part II. Other significant conditions	contributing to death but not re	esulting in the u	nderlying cause gr	ven in Part I.		23e. Did toba	e to the cause of death? Probably 4 Unknown		
Vital Records,		Completed							24a. Was an autopsy perform 1 Yes 2	ed2 prior	e autopsy findings available to completion of cause of h? Yes 2 \sumbox No	
Vita	Physicien: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) Yes	Hospital:	☐ ER/Outpatier	nt 3 DOA Ott	ac.		heck only one) ice 6 □Other (S	Engelie	
ion of	te le	 -	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injui Wo	ry at	28d		v injury occurred	эреспу	
Division	iel or Attending s after death. al Director; Afte ed in by the fune	Certification:	3 Suicide 6 Could not be determined		home, farm, str city)	eet, factory, office		28f.	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospitel or Atte within 24 hours after de To the Funeral Direct completely filled in by th	Medical C	29a. Certifier (Check only one) 1 Certifying Pl 2 Medical Exa	hysician: To the best of my kr miner: On the basis of examin and manner stated.	nowledge, death nation and/or in	n occurred at the till vestigation, in my o	me, date and opinion, deat	d place, and h occurred :	due to the cau at the time, dat	use(s) and manne e and place, and	r as stated. due to the cause(s)	
	To the Comp	M	29b. Signature and title of certifier	5 0.0		29c. Licens				d. Date signed (M		
,	12		30. Name and address of person who			Print)	-00				e-7, 7005	
	! Ø	te	Matthew Koem 31. Date filed (Month, Day, Year)	32. Agistrar's Sign	nature)	IFE ST	Ba	/timo	e mo	7 21287	7	
	Registr		SEP 1 2 2	32. Agistrar's Sign	H A	0043						

			1 - For State Registrar	State of M	laryland / Do	epartmen Certificat	it of H	ealth an Death	d Mental I		ne 2 0	05	29533
	Physici	an	1. Decedent's Name (First, Middle, Last,					-	2. Date of Month	Death	Day	Year	3. Time of Death
	/Medic Examir	al	James H. Gib 4a. Facility Name (If not institution, give Southern Maryla	street and number		-	Town, or	Location of D	Sept eath	6,	2005 4c. County Princ		23:38 P ^M
	Funeral Director		5. Social Security Number 6. Sex 247 54 8714 6. Sex 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under							, Day, Ye		9. Birthp	lace (State or Foreign
Baltimore, Maryland 21215-0036	d within 72 hours after death with the Maryland Jiene. I't than "neturel", or Heme 23e or 28e-f ehow The Madical Examinat must be notified at	Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince G 10e. Street and Number 12806 Applecros 11. Marital Status 1 Never Married Marned 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade) Elementary/Secondary (0-12)	S Drive 12. Was Deceden Armed Forces Milyes 2 Hyes, Give Year or Dates: cation e completed)	Ever in U.S. No 1955 1977	Clinton 104. Zip	20 dent of His city Cubar No	Specify:	? (Specify Yes o uerto Rican, etc. working	T No-		State - America k, White, Afr	es an Indian, etc. rican
	be file ital Hyg id othe event,	То Ве Соп	12 17. Father's Name (First, Middle, Last) Andrew Gibson	College (1-4or	3 1	Militar	У		Name (First, Mic	ddie, Mai			.ger
	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If Item 27 Is marked any Injury or other treumatic ev <u>once.</u>	T	19a. Informant's Name/Relationship (7) Juliette Gibson 20a. Method of Disposition 1 X Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Fureral Service Lie s	(Wife)	20b. Place of E	806 App Disposition (National Community of C	lecro	oss Dri Sept Cemet	r Rural Route Nu Lve, Cli 14 ^{Pate} 200	nton 5 200 Ch	ity or Town, , MD c. Location - eltenh Home,	2073 City or To nam, Inc 6	own, State Maryland
Physician /Medical Examiner	/Medical Examiner hysician and purial-transit	dical Examiner	23a. Part 1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	s a consequence of CFF	ot enter the moo	de of dying	, such as car		ry arrest			Approximate Interval Between Onset and Death
.O. Box 6	ne death certific the ettending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 Fetal death at time of death	3 □Ectopic p 5 □ Other (sp				_	23d. Dati Mor	e of delive	ery Day Year
<u>α</u>	The law requires that the tast that the has been signed by bage 2 should be detact	b	Part II. Other significant conditions co	ntributing to death	but not resulting in t	the underlying o	cause give	n in Part I.				ibute to th	ne cause of death?
Vital Records,		Completed	Ger	My	d ord	mi	15,0		l a	Vas an lutopsy lerformer es 217		rior to cor leath?	psy findings available mpletion of cause of 2 No
of	Attending Physician: Th r death. ector: After this certificate by the funeral director, pag	tion; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 V Inpat 28a. Dat of In (Month, D	urv 28b. Tir		28c. Injury Work	n: 4 🗆 Nursir	Death (Check or ng Home 5 🗆 F 28d. Descr	Residenc	e 6 ⊡Othe		1)
Division	in Diffe	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inbuilding, e	njury - At home, fam tc. (Specify)	n, street, factor	y, office			on (Stree Town, S		er or Rura	l Route Number,
	he Hospitel in 24 hours a the Funerel I pletely filled	edicai	29a. Certifying Phy (Check only one) 2 Medical Exami		t of my knowledge, of examination and/ stated.					me, date	and place, a	nd due to	the cause(s)
)	To the within 2 To the complet	2	29b. Signature and title of certifier	2 au	mely	29	c. License	number 24208		29d.	Date signed	(Month,	Day, Year)
			30. Name and address of person who co	omplited cause of	death (Item 23a) (T	ype, Print) 8	92	6000	10 ya	net	2 RC	55	101
	Sta Regist		31. Date filed (Month, Day, Year) SEP 1 2 2005	3. Regis	trar's Signature	books		- 6017		· u =	~	75)

5-6100 KG		= For Unpend Item 2	State of Mar 3a, pt.II,2	yland / Dep.	artment of l	lealth and	Mental Hyg	iene 2	005 295.				
		Registrar 1. Decedent's Name (First, Middle, Last,		Ce	runcate of	Death	2. Date of Deat		005 295, 3. Time of Death				
Physician	n	Kimberly A.	_	ner			Month Septemb	Day	Year 2005 4:59 A				
/Medica Examine		4a. Facility Name (If not institution, give Mercy Hospital	street and number)		4b. City, Town, o	or Location of Dea		4c. County					
Funeral Director		219-70-0123	7. Age ((In yrs. last birthday) 46 Yrs.	If Under 1 Year Months Days			Year) 1959	Birthplace (State or Foreig Country) MD				
pue Mo	-	Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or Le	ocation				10d. Inside City Limits				
atter death with the Marylen ritems 23e or 28e-1 ehow ritems 25e or 28e-1 ehow rites the notified at	ector	Maryland Anne Ar	undel		Chur	rchton	11	1 ☐ Yes 2 ☐ No					
Sa or	2	5458 Deal-Church	ton Road			20733		-	SA				
death ms 2	Lera Lera	11. Marital Status	12. Was Decedent Ever Armed Forces?	er in U.S. 13.	Was Decedent of H	Hispanic Origin? (Specify Yes or No- rto Rican, etc.)	14. Race	e - American Indian,				
1215-0036 within 72 hours after death with the Maryland ana. then "natural, or items 23e or 28e-f show he Medical Examinar must be notified at	2	1 Never Married 2 Married 3 Widowed 4 XDivorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐XNo		no Alcan, etc.)	Specify	ock, White, etc. by: White				
72 hg	erec	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	pation during most of wo	16b. Kind of Business/Industry						
within within then then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	Sales	na)		Reta	ail				
be filed wit tal Hygiens of other the	5	17. Father's Name (First, Middle, Last)			50163	18. Mother's Na	me (First, Middle, N						
aryland should be marked o martic eve	0	Fred Unknow	n			Patrici	ia Joha	anson					
Mar nd 2 sho lith and 27 ie m r treum		19a. Informant's Name/Relationship (Ty Joshua Davis	рв, Print) (SON)		ng Address (Street Dunlape								
other tr	1	20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other pla	sep	t. 13	20c. Location -	City or Town, State				
Page Page Thent cannot be and: If ury or		1 XBurial 2 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Glen Hav			2005	alen Bur	rnie, Maryland				
Baltimore, permit. Pages 1 et Department of Hee Important: If tem eny injury or othe		21. Signature of Funeral Service Loan	*	2	2. Name and Addre		Stallings oad, Pasa		1 Home, P.A.				
System and business are supposed business.		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and the cause (Disease or injury that initiated events resulting in death) Last											
VISION Of VITAI RECORDS, P.O. BOX 687 Attending Physician: The law requires that the death certificate releath. •ctor: After this certificate has been signed by the attending phys by the funeral director, page 2 should be detached for use as tha fifcation: To Be Completed by Physician/Medic		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 yes 2 No	3c. If yes, outcome of 1 ☐ Live birth 2 [4 ☐ Pregnant at tirn 9 ☐ Unknown	у		23d. Date Mon	e of delivery oth Day Year						
S, P	<u> </u>	Part II. Other significant conditions cor	_				23e. Did tob	acco use contr	bute to the cause of death?				
w require been si should t	3	Status Post Endoca	rditis and	Sepsis, R	enal Fail	lure,	1 ☐ Ye	s 2 🗆 No	3 Probably 4 Unknown				
Division of Vital Records, or Attending Physician: The law requires t after death. Director: After this certificate has been signed in by the funeral director, page 2 should be pertification: To Be Completed by	pid III	Hypertension,Drug	Use				24a. Was ar autopsy perform 1 X Yes 2	ned? pi	Vere autopsy findings available rior to completion of cause of eath? Xes 2□ No				
/ita	ם ב	25. Was case referred to medical examiner?			12.		ath (Check only one	e)					
Physic this c all dire	2	1 Yes 2 No Page 1 No Page		2 ER/Outpatier	" SO DOX		Home 5 Resider						
ding I		1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day)	Injury		ryat rk? IYas 2¶∏ No	28d. Describe ho	w injury occurre	o unk				
Division of Vital Re Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	פונוונט	2 Accident investigation 3 Suicide 4 Homicide ACCould not be determined M 1 Yes Mark No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Scene						reet and Number . State) 5458 urchto n	er or Rural Route Number, B Deale Church				
Hospita 4 hours Funera aly fille	2	(Check only 2 XMedical Examin	Bician: To the best of ner: On the basis of ex	camination and/or in	h occurred at the tir vestigation, in my c	me, date and place	e, and due to the ca	use(s) and mar	<u> </u>				
thin 2 the I	-	one) 29b. Signature and title of certifier	and manner stated	d.	29c. Licens				(Month, Day, Year)				
T with		· Culinula	RAR		0.C	.M.E.		_	er 7, 2005				
		30. Name and address of person who co	mpleted cause of deat			treet, Ba	altimore,	Marylar	nd 21201				
State Registrar		31. Date filed (Month, Day, Year) SEP 1 2	32. Reg (ars	Signature	Bull		•						

State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Month Day 10 2005 **Physician** 7:05 P.M HOBBS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. HOSP ITM RANDALL BIALTI more If Under 1 Year 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**X**M 2□ F 212-46-7522 65 Director 28 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Sukesville 1 □Yes 2 No Director MD Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 253*5* Arthur 21784 USA 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry SHA Peges 1 and 2 should be fited within nent of Health and Mental Hygiene. int: if item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) I ransportation Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Hobbs Sellman Lillian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2535 Sykesville MD 21784 Wilson Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Springfield Cometery 4/14/05 Sykesville 122. Name and Address of Pacility Haight Funeral and Chapel injury or 21. Signature of Funeral Service License Sykesville MD 21784 6416 Rte 32/PO BOX 23a. Part 1. Enter the disease, or complications shock, or heart allure. List only one cause Approximate Interval Between Onset and Death at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o) as a consequence of) Examiner the attending physicien end hed for use es the burial-transit The faw requires that the death certificate be executed ren Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed?
Yes 2 No To the Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No Inpatient 2 ER/Outpatient 3 DOA 1 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After this funeral d 27. Manner of Death 1 Natural 2 Accident te of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; Injury 5 Pending 1 ☐ Yes 2 ☐ No hours efter death. investigation Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

All Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and a ss of person who completed cause of death (Item 23a) (Type, Print) DRWE Chillen Vices sur 31. Date filed (Month, Day, Year) SEP 1 2 2005 3. Registrar's gignature State Registrar Carlo Ca

			For State Registrer	State of N	/larylan	-	artmen <i>rtificat</i>			ind M	R	leg. No.	200	5	295	36
	Physici		1. Decedent's Name (First, Middle, Emory Oliver Ha				_				2. Date of Dea Septemb		7, 20 0		Time of Deat	h pM
	/Medio Examin	er	4a Facility Name (If not institution, Glade Valley Nu	4a Facility Name (If not institution, give street and number) Glade Valley Nursing & Rehab Center						4b. City, Town, or Location of Death Walkersville 4c. County of Deat Frederick						
	Funeral Director		5. Social Security Number 212-01-4762	S. Sex 7. A	Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birth	/ T9 20	9. Bir MD	nthplace ountry)	(State or Fore	віgn
	פ		Usual Residence of Decedent											1404	0: 1:	-14 -
	arylar show	_	10a. State 10b. County MD Carrol	1		y,Town or Lo									Inside City Lin X 1 □ Yes 2 □	
	Be-f.	cto			7.		_									
	h with th	ai Director	10e. Street and Number 6210 Oak Hill D:	rive									Citizen of What Country? USA			
36	ı within 72 hours after death with the Maryland liene. r than "neturel", or Itams 23a or 28e-f show The Medical Examinet must be molified at	by Funeral	11. Marital Status X 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deceder Antified Force d 1 Tyes 2 [If Yes, Give Year or Date:	s? ∃No		Was Deced If Yes, special 1 Yes	X	spanic Origin, Mexican Specify:	gin? (Spe i, Puerto	cify Yes or No- Rican, etc.)		Race - Am Black, Whi		ndian,	
ö	hou ture	ed	15. Decedent		ation 16a Deced				tion			16b. Kind	of Business	/Indust	ry	
21215-0036	within 72 iene. than "ne he Medis	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4c	or 5+)	(Give life. Color	kind of wo DO NOT u 1e1	rk doné d se retired)	uring mos	t of worki	ng	US Ar	my			
	be filed tal Hyg d other	Be	17. Father's Name /First, Middle, L. Pather's Name /First, Middle, Sr.	ast)					18. Mothe	rs Name Minnie I	(<i>First, Middle,</i> Vlarie Schim	Maiden Su P	mame)			
Maryland	d 2 shou th and M ?7 is mar traumat	ဥ	19a. Informant's Name/Relationsh Karen Hasenei (p (Type, Print) Franddaugh	iter)						I Route Number, City or Town, Star rederick, MD 217					1
Baltimore,	1 and Healt em 2 ther		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from Sta		Place of Disponentery, cre	matory or c	ther place	9)		2 05		tion - City or more,			
Ë	TT T		° 4 ☐ Donation 5 ☐ Other (Sp	ecity)	WOO	odlawn			1	- /				Hary	/ Lanu	_
Bal	permit. Depertm Imports any inju		21. Signature of Funeral Service L	L. Har	glot		aligner O.O. B		ialiach 5 Sy	bme kesv	& Chapel ille, Ma	, P.:	A. d 2178	34		
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as care shock, or heart failure. List only one cause an each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a typic sequence op:									re	seelo		serv	Inte On	proximate erval Between set and Death		
		je.	S uentially list conditions, if any, leading to immediate cause. Enter Underlying	uence vi).	sein							0				
	cuted nd ransit	Examiner	that initiated events	ensi								4	cars			
8760,	ite be executed ysicien and ne burial-transit	cai Ex	resulting in death) Last	Due to (or	at a conseq	uence of):										
O. Box 6	law requires that the death certificat as been signed by the attending phy 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2, No		Ectopic pregnancy Other (specify)					23d. Date of delivery Month Day Year						
Records, P.	uires thai signed t Id be det	þ	Part II. Other significant condition	ns contributing to death	n but not res	ulting in the u	underlying o	ause give	n in Part I	•	23e. Did to			to the ca Probably	ause of death	
Sor	w requ	Completed	a she Vil	r rell	مرم م	12					24a. Was		24b. Were a	utopsy	findings availa	able
Re	he h	mo du		7		- 101					autop perfor		death?	x	ition of cause No	UI
Vital	ian: T	0	25. Was case referred to medical						26. Place	of Death	(Check only o					
Į <	nysic is ce direc	To B	examiner? 1 🗆 Yes 2 No	Hospital: 1 ☐ Inp	atient 2	ER/Outpatie	nt 3 D	OA Othe	r: AUNI	ırsing Ho	me 5 Resid	lence 6 [Other (Spe	ecity)		
n of			27. Manner of Death 1 Natural 5 □ Pending	28a. Date of I (Month,	njury Day Year)	28b. Time of Injury		28c. Injury Work			28d. Describe h	ow injury o	occurred			
sio	Attendidate death.	catio	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	ation			М		/es 2□		28f. Location (S	Name & a mod &	lumba a sa F	Dung (Da	udo Alumbos	
Division	of or Attend efter death Director: , d in by the f	Certification:	4 Homicide determi	289. Place of	etc. (Special	ome, farm, si	treet, factor	y, office			City or Tow		vumber or P	iurai Ac	oute ivamber,	
	To the Hospitel or Attending within 24 hours effer death. To the Funerel Director: Atte completely filled in by the fune	Medicai C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the be examiner: On the basis and manner	s of examina	owledge, dea ation and/or in	th occurred nvestigation	at the tim	e, date ar pinion, dea	id place, ith occurr	and due to the ded at the time, d	cause(s) and pl	nd manner a ace, and du	s stated	d. cause(s)	
	To th within To th comp	Me	29b. Signatule and title of certifier				29	c. License		. /		29d. Date s	signed (Mon	th, Day	44	_
) h			ALVES					12	65	16		Sef	T	0	2005	>
1)		30 Name and address of pecson	the completed cause	of death (Iter	n 23a) (Type	Print)	NES	1A	VE	FRA	ERI	CH	MD	217	9.5
	Sta	ite	31. Date filed (Month, Day, Year)	2005 37 Reg	istrar's Signa	ature A	and D	/			,			/		
	Regist		SEP 1 2	COOL COOL	Alle &	S. S	A - Same									

			1 = For State Registrar	te of Maryland / Depa <i>Cer</i>	artment of He rtificate of D	eaith and Me Death	ntal Hygle Reg.		29537
- 2	Dhusisi		Decedent's Name (First, Middle, Last)			2	Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		111.12.21	DSON			aug.	31 2005	
	Examin	er	4a. Facility Name (If not institution, give street a	A 0 4 A	4b. City, Town, or			4c. County of Deat	h
-	9- Fag.		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Baltimo		L Date of Birth	N/A	holace (State or Foreign
į,	Funeral Director		251-64-1976 *** 20		Months Days	Hours Min.	Date of Birth (Month, Day, Ye)	1939S. C	hplace (State or Foreign untry) Carolina
	ehow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	the Ma	Director	Maryland N/A	Balt	i more		10a.	Citizen of What Co	Yes 2 No
	3e or		3419 Royce Avenue			21215		USA	
	deat	Funeral	11 Marital Status 12. Wa	s Decedent Ever in U.S. 13. Ved Forces?	Was Decedent of His	spanic Origin? (Spec n, Mexican, Puerto R	fy Yes or No-	14. Race - Ame Black, White	
980	s i and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 ie marked other then "naturel", or items 23e or 28s-f show other traumatic event, the Medical Examinatings the rivilial at	þ	1 Never Married 2 Married	Yes 2 □ No	1 ☐ Yes 🏋 ☐ No	Specify:	July 5101,	Spec Balac	•
21215-0036	in 72 ho n "natur Nedical	Completed	15. Decedent's Education (Specify only highest grade comp	leted) (Give	dent's Usual Occupa kind of work done di DO NOT use retired)	uring most of working	7	b. Kind of Business/	Industry
212	12 should be filed within: n and Mental Hygiene. r ie marked other then " reumatic event, tre Mac	mo	Elementary/Secondary (0-12) Coll 12th grade	ege (1-4or 5+) Stee	el Worke	r	Be ⁻	thlehem	Steel
P	al Hyg	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name (den Sumame)	
yla	Ment Ment arked	0	Harry Hudson, Sr.			Leona Ja			
Maryland	12 sh h and 7 ie m rraum		19a. Informant's Name/Relationship <i>(Type, Pri</i> Rosa L. Hudson/Wife		•	nd Number or Rural		*	
	1 and Healtl em 27		20a. Method of Disposition	20b. Place of Dispo	sition (Name of	ve Balti	te 200	c. Location - City or	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 ie eny injury or other trau <u>once</u> .		M Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	Garrison		Vet. Ce	m. Ow:	ings Mil	ls, Maryla
Ball	Depart Depart Import eny in		21. Signature of Funeral Service/Licensee						neral Home Md 21215
	. 2		23a. Part . Enter the disease, or complications anock, or heart failure. List only one caus	that caused the death. Do not ent	er the mode of dying	, such as cardiac or	respiratory arrest	,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		nbolism				Onset and Death
	/Medical Examiner		resulting in death)	ue to (or as a consequence of):					
		10	Sequentially list conditions. b	ua to (or as a consequence of).					
	uted I Insit	min	cause. Enter Underlying Cause (Disease or injury	(-					
ć	exection and and rial-tre	Examiner	that initiated events c. resulting in death) Last	ue to (or as a consequence of):					
68760,	ificate be executed g physicien and as the burial-transit	edicai	d.						
	E D a		IF FEMALE:						
P.O. Box	w requires that the death certif been signed by the attending should be detached for use a	Completed by Physician/M	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
	that the	y Ph	Part II. Other significant conditions contribution	g to death but not resulting in the u	nderlying cause give	n in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Division of Vital Records,	requires wen sign hould be	ed b	Emphyseine	7. Hypesten	our.		1 🗆 Yes	2 □ No 3 ☑ Pr	obably 4 □Unknown
ွဲ	aw re	piet	V	01			24a. Was an autopsy	24b. Were au	itopsy findings available completion of cause of
<u>~</u>	The law ate has by page 2 st	E O					performe	deatn?	2 No
/ita	cian: ertific	Be	25. Was se referred to medical examiner?		l a	26. Place of Death	Check only one		
₹	Physician: this certific ral director,	10	1 Ves 2 No Hospital	Impatient 21 ENOutpatien		4 Nursing Hom		e 6 Other (Spe	cify)
no	و آق ق	tion	1 Spiratural D 1 Origing	Date of Injury (Month, Day Year) 28b. Time of Injury	Work	at ? ′es 2 □ No	d. Describe how	injury occurred	
is	death. ctor: A y the fu	fical	3 Suicide 6 Could not be 28e	Place of Injury - At home, farm, str			If. Location (Stree	et and Number or Ru	ural Route Number,
Div	al or Atten s after deal if Director id in by the	Certification:	4 Homicide determined	building, etc." (Specify)			City or Town, S	State)	
	To the Hospital or Attendis within 24 hours after death. To the Funarel Director: A completely filled in by the fu	Medical C	(Check only 2 Medical Examiner: Or	To the best of my knowledge, death the basis of examination and/or in d manner stated.	h occurred at the time vestigation, in my op	e, date and place, ar inion, death occurred	nd due to the caus d at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
_	To the within Fo the comple	Me	29b. Signature and title of certifier		29c. License	number	29d.	. Date signed (Mont	h, Day, Year)
	_/		Landy WAR	an wo	DOC	21730		aug. 31	2005.
	119		30. Name and address of person who complete	d cause of death (Item 23a) (Type,		. , ,		0	21215
	11		Taria Khan	Dinai	Hosp	.tal	159 to	o.Md.	21215
7	Sta Regist		31. Date filed (Month, Day, Year) SEP 1 2 2005	32. Pogistrar's Signature	nach s				
4				I STATE A RE AND	100				

			For State Registrar	State of Ma	aryland / E	Departmen	t of He	ealth a	and Me	ntal Hvgi	iene 200	
			Registrar 1. Decedent's Name (First, Middle	(ast)		Certificat	e of L	<i>Death</i>		. Date of Death	g. No. 200	5 29538 3. Time of Death
П	Physici		Phillip '							Month 19ust	Day Yea	
	/Medic Examin		4a. Facility Name (If not institution			4b. City,	Town, or	Location o		agust	4c. County of De	
			Anne Arundel	Medical Co	enter (In yrs. last bin	Ann	apo:	lf Under	0411-2		Anne A	
	Funeral Director		5. Social Security Number 220-05-3093	6. Sex 7. Age		Yrs. Months	Days	Hours	Min.	Date of Birth (Month, Day, 101 • 2	9. 8 1910 Mai	lirthplace (State or Foreign Country) Cyland
	D		Usual Residence of Decedent						43.0	19. 2	IDIO Mai	Lytand
	show	J.	10a. State 10b. County		10c. City, Town	n or Location						10d. Inside City Limits 11 Yes 2 □ No
	28a-f	Director	Maryland Anne 10e. Street and Number	Arundel	Annai	001is	Code			10	Og. Citizen of What	
	h with			Over als (Flance								·
	ems a	ner	103 College (12. Was Decedent 8 Armed Forces?	ver in U.S.	13. Was Deced	401 lent of His	spanic Orig	gin? (Specif	fy Yes or No-	14. Hace - Ar Black, Wi	nerican Indian,
36	s afte	by Funerai	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 Tes 2 17 N If Yes, Give Year or Dates:	lo	1 ☐ Yes	-	Specify:		,,	Specify:	Black
21215-0036	within 72 hours after death with the Maryland ene. Then "natural", or Items 23a or 28a-f show healtest Exercites must be notified at	ted t	15. Decedent	's Education	16a.	Decedent's Usua				1 1	16b. Kind of Busines	
218	ithin 7 19. 19. "n	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4or 5	+)	(Give kind of wo life. DO NOT us	rk done di se retired)	uring most	t of working			
	iled willed will will will will will will will wil		10th 17. Father's Name (First, Middle, I	0		Machin				Time Adidalla As	Annapoli	s Dairy
anc	d be filed antal Hygi ced other c event, I	To Be	William 1								faiden Sumame)	
Maryland	should and Men s marke umetic	-	19a. Informant's Name/Relationsh		19b.	. Mailing Address	(Street ar			Enni Route Number,	S City or Town, State	, Zip Code)
	and 2 ealth a n 27 is		Mary L. Pincl	ney (Daugh		610 Wa	ywar	d Di			is, Md.	21401
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Healih and Menlar Hygiene. Importent: If item 27 is marked other than "natural; or Items 23a or 28a-f show eny injury or other treumetic event, It a Marical Exacting must be notified at once.		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation	3 Removal from State	cemeter	Disposition (Namy, crematory or o	ther place		Date		20c. Location - City of	or Town, State
Ħ	nit. Pa antmer ortent injury 1.		* 4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service I		Park	gate Me	MOT 1	Lation	9/8/0)5 A	nnapolis	Md.
Ba	permit. Departr Importe eny inji			Beese MOO	483	Wm. R	eese	3 & 5	Sons	Mortu	ary, P.A	polis. Md.
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused	the death. Do r	not enter the mod	e of dying	, such as	cardiac or r	espiratory arre	st,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	_a. M_	ocar	dul		Int	Tave	7.0.	1	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or * a	a consequence of	of):						
	CO.	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	a consequence (of):						ļ — — — — — — — — — — — — — — — — —
V	rcuted nd transit	Examiner	Cause (Disease or injury that initiated events	с								
8760,	cate be executed physician and the burial-transit	icai Ex	resulting in death) Last	Due to (or as a	a consequence of	of):						
l Records, P.O. Box 68760, <	ficate p physics ts the l			d								
ŏ	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		3 □Ectopic pr	ennancy				23d. Date of d	elivery
о. В	the att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐ Unknown		5 Other (sp					Month	Day Year
<u>.</u>	res that the de signed by the a be detached f	/ Ph	Part II. Other significant conditio	ns contributing to death bu	it not resulting in	the underlying c	ause giver	n in Part I.		23e. Did toba	acco use contribute	to the cause of death?
Records,	quires n sign uld be	ed by								1 ☐ Yes	s 2000 301	Probably 4 Unknown
900	has been si	Completed								24a. Was an autopsy	24b. Were a	autopsy findings available completion of cause of
ř	the cate ha	Сош								perform	ed? death?	es 2 No
Vita	sicien certifi rector	Be	25. Was case referred to medical examiner?	Hospital:			Other	r-		Check only one		
0	Attending Physicien: r death. sctor: After this certific. by the funeral director.	n: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injur	y 28b. T	ime of 2	Bc. Injury : Work?	4 LI NUI	3		nce 6 Other (Sp w injury occurred	ecify)
ion	ending sath. or: Aft he fun	atio	2 Accident 5 Pending investig	ation	rear) Ir	njury M		r es 2□N	No			
=	after de Direct Jin by t	Certification:	3 Suicide 6 Could n 4 Homicide determi	ot be ned 28e. Place of Inju building, etc	ry - At home, far . (Specify)	rm, street, factory	, office		28f	. Location (Stre City or Town,		Rural Route Number,
	Hospitel 24 hours a Funerel I etely filled		29a. Certifier Certifying	g Physician: To the best o	of my knowledge	death occurred	at the time	date and	d place, and	due to the car	use(s) and manner a	as stated
	To the Hospitel or Attending Physicien: The is within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	edical	(Check only 2 Medical 8 one)	xaminer: On the basis of and manner sta	examination and	d/or investigation,	in my opi	nion, deat	th occurred	at the time, dat	te and place, and du	ue to the cause(s)
	To the To the comple	Σ	29b. Signature and title of certifier	91	MN	290	License	number	87	29	d. Date signed (Mor	nth, Day, Year)
			1 Chine	4	MO		レン) (0		9111	کرد
	5		30. Name and address of person v	who completed cause of de	eath (Ipem 23a) (Type, Print	[]	(M	2. 160	(C.	n ter
	Sta		31. Date filed (Month, Day, Year)		r's Signature	0		5.1	+ 1		1 40	
	Registr	ar	SEP 1 2	2005	. M.	bootes						

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State of Maryland	Department of H	ealth and Mental	Hygiene 2	005	2

		•	For State Registrar	State of Maryland	Cei	tificate of	Death	Reg	J. No.	
Ph	ysicia	ın	1. Decedent's Name (First, Middle, La EDWARD GRUNELL					2. Date of Death Month	er 3, 2005	3. Time of Death 0109 A M
	Medic		4a. Facility Name (If not institution, given 1950 Arwell Cour	e street and number)		4b. City, Town, c	r Location of Death	pepremb	4c. County of Dear	th
	eral ctor		5. Social Security Number 6. 5		st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1-15-19		thplace (State or Foreign ountry) RYLAND
e Maryland	titled at	ctor	Usual Residence of Decedent 10a. State 10b. County MD • ANNE ARU		Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
with th	thene	i Dire	10e. Street and Number 1821 MEADE CIRC	LE RD.		10f. Zip Code 2114	4	10	g. Citizen of What Co USA	untry?
1215-0036 within 72 hours after deeth with the Maryland ene, then "naturel; or Items 23a or 28a-1 show	2	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ectly Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: B.	te, etc.
21215-0036 Id within 72 hours att giene; srthen "naturel; or	edical	Completed	15. Decedent's E (Specify only highest gr	ade completed)	16a. Deced	dent's Usual Occup	oation during most of worki d)	ing 1	6b. Kind of Business	Industry
N oak	Ene M	omo	Elementary/Secondary (0-12) -10-	College (1-4or 5+) — 0—		BORER			TRONG HOL	D CONCRETE CO
Maryland 2 od 2 should be filed lith and Mental Hygis 27 Is marked other	tic event,	To Be C	17. Father's Name (First, Middle, Last EDWARD G. HOWAR				18. Mother's Name CHRIST	(First, Middle, Middle		
Te, Ma 1 and 2 s Heelth ar	other trau		19a. Informant's Name/Relationship (CHRISTINE BROOK 20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	S (MOTHER) 20b. Pla CB Removal from State	182 ace of Dispo metery, crer	21 MEADE sition (Name of matory or other pla	CIRCLE RD	SEVERN	MARYLAN City or Town, State, A MARYLAN Co. Location - City or NNAPOLIS,	D 21144 Town, State
Baltimol permit. Pages Department of	eny inju		21. Signature of Eugeral Pervice Lice			2. Name and Addre	M1.1.	REESE &	•	TUARY, P.A.
CRY60, Criticale be executed Exam	iner iner	ai Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence) Due to (or as a consequence)	Do not ent NCM of ence of):	er the mode of dyin	ng, such as cardiac o			Approximate Interval Between Onset and Death
. Box 687 death certificate e ettending phy	as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnan 1	death 3	Ectopic pregnanc Other (specify)	•		23d. Date of de Month	livery Day Year
P tat D	8	፩	Part II. Other significent conditions	contributing to death but not resul	lting in the u	nderlying cause giv	ven in Part I.	23e. Did toba		o the cause of death?
E Pe Le	rector, page 2 should t	Completed						24a. Was an autopsy perform	prior to ed? death?	utopsy findings available completion of cause of
of Vita Phyalcian: rthis certifica	director	To Be	25. Was case referred to medical examiner? 12□Yes 2□ No	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatier	nt 3 DOA Ott	26. Place of Death		ce 6 Other (Spe	at scene
VISION Of Attending Phy r death.	by the funeral o	Certification; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	28c. Inju Wo A M 1	y at rk? Yes 2 (No	28d. Describe how	vinjury occurred	
Ospital or Al hours after of uneral Direct	.=		Homicide determined	Building, etc. (Specify)	Alley			Severh	m7	nell aunt
ne Hospital	completely filled	Medical		nysician: To the best of my know miner: On the basis of examinati and manner stated.						
To the Ho within 24 F	Сощо	W	29b. Signature and title of certifier	M It	-	29c. Licens			d. Date signed (Monte	
-			30. Name and address of person	70		Print)				
Re	Sta egistr		31. Date filed (Month, Day, Year) SEP 1	32. Registrar's Signati		_	et, Baltım	ore, Mar	yland 2120	Л
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Please Type of Print in Black Indelible lak. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number 4c. County of Death Examiner Birthplace (State or Foreign Country) Date of Birth 7. Age **Funeral** 1 ☐ M 2 💢 F Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mentat Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "naturel", or Items 23a or 28a-1 show any injury or other treumatic event, It a Marked Examination use to confire a once. 1 s 2 No Director 10g. Citizen of What Country? 10e. Stre 10f. Zip Code Completed by Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ecedent Ever in U.S. Armed Forces 1 Never Married 2 Married ☐ Yes 2 No Yes, Give Specify. 1 ☐ Yes 2 📉 No Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
(life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) bliege (1-4pr 5+) Elementary/Secondary (0-12) ecu ministrative 18. Mother's Name (First, Middle, Maide 17 Father's Name (First, Middle, Last Be Journal September 1997 SE 2 ZnGode) 21206 19b. Mailing Address 821 and Number of Run Rough Number Care Method of Disposition

Bunal 2 Cremation 3 □ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 1 Euro 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hepatocelly Physician avcinoma disease or condition resulting in death) May /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. IF FFMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? for 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à pe 1 Yes 2 No 3 Probably 4 Unknown the funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2 No 1 Yes 1 Yes Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 🔲 Inpatient Other: 4 Nursing Home 2200 5 Residence 6 Other (Specify) 1 🗌 Yes 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After t or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide Hospital within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 02 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fulls RD MO 3730 Daltimore egistrar's Signature 31. Date filed (Month, Day, Year) State 2 2005 1 Registrar

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

32. Registra Signature

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O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

September 8, 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 16a per fh 984/ 9-12-05 vt
State of Maryland / Department of Health and Mental Hygiene 0 15

29542 1 - For State Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Rodney Jones Sr. 2005 30 9:30 p August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crownsyille

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Fairfield Nursing Center Arundel Anne Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** 1☑M 2□F Yrs Director 214-05-1006 Usual Residence of Decedent 25 1921 Maryland death with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits item 27 ie marked other than "neturel", or items 23e or 28a-f show other traumatic event, itte Medical Examinar must be motified at 1⊠Yes 2 No Direct Maryland Anne Arundel Annapolis 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 21401 South Villa USA Avenue permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "neturel" ~ any injury or other traumatic events. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 GYes 2 No If Yes, Give Year or Dates: 1943-45 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retirmanager Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Equipment Monager US Naval Academy 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lou Jones Clarence Olney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beatrice V. Jones (Wife) 110 South Villa Ave. Annapolis, Md. 21401 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veteran 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State ¹ 4 □ Donation 5 □ Other (Specify) Comotory Name and Address of Facility 9/7/05 Crownsville, Md. 21. Signature of Funeral Service Licenses Reese & Sons Mortuary, West St. Annapolis, Md. Wm 82 Lavy G, Reese MOOY83 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Due to (r as a consequence of): rtill who /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕦 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 No 2 No To the Hospitel or Attending Physician: the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient Other: 4 30 ursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 300 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After t 1 Natural 5 Pending Injury after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of MD 38958 30. Name and address o person who completed cause of death (Item 23a) (Type, Print) Highway Sw Glan Burnie MD 21061 Date of (Month, Day, Year) 208 1240 collen 32. Registrar's Signature State Registrar 2 2005

State of Maryland / Department of Health and Mental Hygiene 2005 29543 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 5:45 PM April Jones 8 30 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Good Samaritan 105 If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. 1 □ M 2 Hours Months 215-86-5937 Director 40 04/23/1965 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Director Md N/A Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1425 Stromeyer Way U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. 1 Never Married 2 Married 1 Yes 25 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) is marked other than College (1-4or 5+) N/A. Pages 1 and 2 should be filed timent of Health and Mental Hygie tant: If item 27 is marked other jury or other traumatic event, III Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Cleotha Berry ို Arlene Stoner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlene Weatherbee 1300 E. Lanvale Street Apt 404 Baltimore, Md 21213 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or * 4 □ Donation Green Mount 09-10-2005 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wise Funeral Services P.A. 700 S. Beechfield Ave Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** maio myo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed LVY resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, LD IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Certification; To Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed 1 Yes 204 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) the funeral 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation Injury 1 Yes 2 No within 24 hours after death To the Funeral Director: 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) istrar's Signature State Registrar

	-	For Stete Registrar	State of	of Maryland	-	irtment of H tificate of L		l Mental Hygi	ene g. No. 2	005	29544
Dhusiair		1. Decedent's Name (First, Middle,						2. Date of Death Month Septemb		Year	3. Time of Death
Physicia /Medic	al		Kreimer			4b. City, Town, or	Lagation of De		er 9,		1:30am M
Examin	er	4a. Fecility Name (If not institution, 7000 Sheldon La		imber)		•	ykesvil			arroll	
Euporol			C Cou	7. Age (In yrs. last	t birthday)	If Under 1 Year	If Under 24 H	Irs. 8. Date of Birth			ace (State or Foreign try)
Funeral Director		215-58-7685	5. Sex 1√2 M 2□ F	52	Yrs.	Months Days	Hours M	Jan 6,	1953	MD	
pur *	-	Usual Residence of Decedent 10a, State 10b, County		10c. City, T	Town or La	cation				10	Od. Inside City Limits
Maryli f sho	ō	MD Carro	11			Sykes	ville				1 ⊟Yes 2 ⊟Xio
r 28a- notif	Director	10e. Street and Number	711			10f. Zip Code	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10	g. Citizen of	What Count	try?
th with	ai D	7000 Sheldon La	ane				21784				USA
ems	Funeral	11. Marital Status	Armed F	cedent Ever in U.S. orces?	13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? In, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)		ce - America Ick, White, 6	etc.
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be filed within 72 hours after death with the Maryland be filed within 72 hours after death with the Maryland Hygiene. I do ther than "natural", or items 23a or 28a-f show do other than "natural", or items 23a or 28a-f show event, it a Medical Examinar is ust be notified at	Completed	(Specify only highes: Elementary/Secondary (0-12)		(1-4or 5+)	life.	ntenance	1)		Mai	ntena	ance
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and 2 salth a n 27 is		Patricia L. Kri	eimer (S	pouse)	7000	o Sheld	on la				
es 1 so the contract of the co		20a. Method of Disposition 1 □ Burial 2 ▼Cremation	3 □Removal from	cem	netery, crei	sition (Name of matory or other place			20c. Location		
Deficiency Department of I Mportant: If it any injury or o		`4 □Donation 5 □ Other (Sp	necify)	AII		ty Crema		9/13/05			
permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic <u>once</u> .		21. Signature of Funeral Service I	L. Ha	ist	1.	taight fi Sykesvi	the rac	D 21784	CHAI	20 ()-795	PO BOX 195) -1400
THE S		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the death.	Do not en	ter the mode of dyir	g, such as care	diac or respiratory arre	est,		Approximate Interval Between Onset and Death
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/Medical Examiner		rossining in south,	Due to	o (or as a conseque	nce of):						U
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6 / OU, cate be executed bhysician and the burial-transit		resulting in death) Last	Due to	o (or as a conseque	nce ot):						
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death death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time of dea		Other (specify)			N	lonth	Day Year
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OT VICE Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ No]Inpatient 2□El		III 3 DOA		ng Home 5 Reside			y)
on o		27. Manner of Death 1 ☑ Natural 5 ☐ Pendin	9	e of Injury onth, Day Year)	28b. Time o Injury	Wo	ryat rk? Yes 2.⊡No	28d. Describe ho	w injury occu	ırrea	
UNISION OF VITA I or Attending Physician: after death. Director: After this certific if in by the funeral director.	icat	2 Accident investig	not be 200 Pla	ce of Injury - At hom	ne, farm, si		103 2 100	28f. Location (St	reet and Nun	ber or Rura	al Route Number,
after after Direct Dire	Certification;	4 ☐ Homicide determ	bui	Iding, etc. (Specify)				City or Town	n, State)		
DIVISION To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifyir (Check only one)	Examiner: On the	he best of my know basis of examination	ledge, dea on and/or i	th occurred at the travestigation, in my	me, date and popinion, death	lace, and due to the ca occurred at the time, d	ause(s) and nate and place	nanner as si , and due to	tated. the cause(s)
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F S F O		June	o Ku	ules P	VV	D 3	5530	18	4-	7-8	25
107		30. Name and address of person FIAV ON CUTO	who completed ca	use of death (Item 2	23a) (Type	Print) Print)	reet W	Ostmis	6,1	102	1157
St Regist	ate	31. Date filed (Month, Day, Year)		Begistrar's Signatu		code					
negisi	T CI	OLI 1 A	1 2000	LACARD SA	100						

			For State Registrar	State of M	-	artment of H		Mental Hygiene	- 2005	29545
	Physici /Medic		1. Decedent's Name (First, Middle, L Betty	eys				2. Date of Death Month Da SEPTEMBER		3. Time of Death
	Examin			SPITAL		4b. City, orn, or	Location of Death T(M0) If Under 24 Hrs.	RE	c. County of Death	
	- Funeral Director		5. Social Security Number 242-08-1022 Usual Residence of Decedent	.Sex 7. A	ge (In yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Year Sept.	9. Birthe Cour	place (State or Foreign http://Carolina
	Maryland	tor	Maryland N/	4	10c. City, Town or Lo	Bultimor	e		1	1 les 2 No
	h with the 23s or 28s	Funeral Director	10e. Street and Number	ane		10f. Zip Code	229	10g. C	itizen of What Cour	ntry?
036	72 hours after death with the Maryland naturel', or Items 23s or 28s-1 ehow dissal Evantrear must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1	200	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	spanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify: Bla	
21215-0036	within ene. then	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education grade completed) College (1-4or	(Give	dent's Usual Occupa kind of work done of DO NOT use retired Drug Co	furing most of wo	rking	Kind of Business/In	dustry
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-	ges 1 and 2 should t of Health and Men If item 27 is marks or other traumatic		19a. Informant's Name/Relationship Ropsevelt Ke 20a. Method of Disposition	45 - husb	20b. Place of Dispo	ang Address (Street a	S Lan	e Baltin	or Town, State, Zip	ryland
Baltimore	permit. Pages Deportment of Important: If it any njury or o		1 Burial 2 O'Cremation 3 4 Donation 5 Other (Spe 21. Signature of Fun to Service Lic	cify)	Metro	matory or other place MANO /	y 19/11	Has Car Ker Funera	tonsville y Hone	Maryland P.t. 21229
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50,	cate be executed physician and the burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	с. = =	is a consequence of): ALCO (Ho as a consequence of):	c f	7 Bus	٤	U	MUNHAIR
.O. Box 68760	death certific e ettending p d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3 at time of death 5	Ectopic pregnancy Other (specify)			23d. Date of delive	ery Day Year
0	uires that 1 signed b 1d be deta	2	Part II. Other significant conditions Fun GEM	-	but not resulting in the u	nderlying cause give	en in Part I.		use contribute to the	
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Vit.	Physician: this certifice al director, p	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 X No	Hospital: 1 Thpa	tient 2 ER/Outpatie	nt 3□ DOA Othe	or	ath (Check only one) Home 5 Residence	6 ∏Other (Specif	(v)
Division of		ertification; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not	28a. Date of In (Month, D	jury 28b. Time o lay Year) Injury	M 1 1		28d. Describe how inju	ury occurred	
Divi	ital or Attenurs after deat ral Director:	O	4 Homicide determine	building,	njury - At home, farm, st etc. (Specify)			28f. Location (Street a City or Town, Stat	(e)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	ledicai	(Check only 2 Medical Ex	Physician: To the best taminer: On the basis and manner:	of examination and/or in	vestigation, in my or	pinion, death occ	e, and due to the cause(surred at the time, date an	nd place, and due to	o the cause(s)
)	To Yeith	M	29b. Signalure and title of certifier	Theron	hus	Sec. License	6010	SEPT.	TE WI3E12	9, 2005
	3		KARL DUIST.	- /HZRS	death (Item 23a) (Type,	900 CA	tion Au	EMUE BAL	THUMORE M	1821229
6	Sta Regist	-	SEP 1 2		strar's Signature	20				

				Chate of Maniford / Dane		•	_	
				1 - State of Maryland / Department	tificate of Death		2005	29546
		Physici	:- 212	Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
		Physicia /Medic		Harry A. LeBrun, Sr.	Al- Oly The section of Death	Sept.	$\overset{\text{Day}}{9}$, $2\overset{\text{Year}}{0}$	6:10 a ^M
•		Examin	er	4a. Facility Name (If not institution, give street and number) Gilchrist Center	4b. City, Town, or Location of Death TOWSON		4c. County of Death Baltimon	
		Funeral	×,	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth		place (State or Foreign
		Director		213-05-3319 1™M 2□F 88 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day,) 11/6/1	6 Mary	land
		and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lor	cation			10d. Inside City Limits
		Manyli	tor	Md HArford Abe	rdeen			1 ☐ Yes 2 No
		r 28a	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Cou	ntry?
OA		23a c	rai D	700 W. Belair Avenue	21001		USA	
		er dec	une	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Vas Decedent of Hispanic Origin? (Sp. Yes, specify Cuban, Mexican, Puerto	ectfy Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
9	36	irs aft	by Funerai	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No If Yes, Give 1 S ☐ Widowed 4 ☐ Divorced 1 Year or Dates:	☐ Yes 2 No Specify:		Specify:	<i>N</i> hite
	2-0	filed within 72 hours after deeth with the Maryland Hygiene. yther then "neturel", or terne 23e or 28e-f ehow wit, it a Medical Exercited routh be rediffed at	Completed	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give	ent's Usual Occupation	ina 16	6b. Kind of Business/Ir	
	121	ne.	mpie	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of work DO NOT use retired)			
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	lan	id be entai ked o ic eve	To Be	John Hiltz	Minni	ρ.	unknowr	1
	ary	id 2 should be filed within 72 hours after deeth with the Marylan It and Mantal Hygiene. It is marked other then "naturel", or Iteme 23s or 28s-f show traumatic event, Its Medical Exaction must be rediffed at			g Address (Street and Number or Run	al Route Number,	City or Town, State, Zi	Code)
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9/9/05	Baltimore, Maryland 21215-0036	ges 1 If of H If ite		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State			Oc. Location - City or T	
4/0	i i	it. Pa irtmen ortant: njury i.					Dundalk,	Md.
	Ba	permit. Pages 1 and 2 Department of Health a Important: If Item 27 le eny injury or other trau 2005:	4		aczorówskielkun 201 Dundalk Av	eral Ho e. Balt	me P.A. imore, Mo	1. 21222
	- 959			23a, Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.		or respiratory arres	st,	Approximate Interval Between Onset and Death
	}	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence of):	of ducase			years
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Pa	O. E	that the dea ed by the a detached fo	hysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 ☐	Other (specify)		None	Suy . Su.
1	s, P.	The law requires that the death certificate tite has been signed by the attending physoage 2 should be detached for use as the	by Ph	Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
	ords	v require been sig should b			•	1 ☐ Yes	2 □ No 3 □ Pro	bably 4 🗷 nknown
57	Record	e law re hes be je 2 sh	ompieted			24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
3			Con			perform 1 Yes 2		2 No
le	Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:	Other	h Check only one	-	
1	of	ding Phys h. After this funeral dir	n; To	1 ☐ Yes 2 ☐ No ☐	t 3 DOA 4 Nursing Ho	28d. Describe how	tice 6 Other (Special vinjury occurred	N) Vuspice
	ion	ath. or: Afte	atio	2 Accident investigation	M 1 Yes 2 No			
	Division	or Atter de after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, structure building, etc. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	et and Number or Rur State)	al Route Number,
	_	pspital hours a uneral ly filled	_	29a. Certifier Certifying Physicien: To the best of my knowledge, death	occurred at the time, date and place.	and due to the cau	use(s) and manner as	stated.
		To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or invane) 2 medical Examiner: On the basis of examination and/or invane) 2 medical Examiner: On the basis of examination and/or invane) 2 medical Examiner: On the basis of examination and/or invane)	29c. License number		d. Date signed (Month)	
		C1		Marlin	1708312			
				30. Name and address of person who completed cause of death (Item 23a) (Type,		,	eprembu 21204	7000
		4		31. Date filed (Month, Day, Year) 32. Tegistrar's Signatura	mas It Porus.	w m	21204	
		Sta Registi		SEP 1 2 2005				

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** LEVINE 12:45 PM LILLIAN SEPTEMBER 8 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** RANDALLSTOWN BALTIMORE NORTHWEST JATI920H If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. JAN. 4, 1915 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F 216-32-6010 Yrs. 90 W۷ Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other treumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 No Director BALTIMORE OWINGS MILLS MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4730 ATRIUM COURT 21117 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No WHITE Specify: ρ 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **HOMEMAKER** OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be KLEIN **PULVERMAN** REGINA SAMUEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1506 BERWICK ROAD - TOWSON, MD 21204 DAVID WARSHAWSKY / SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State SHAAREI ZION CEMETERY 9/9/2005 ROSEDALE, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): Examiner INFECTION TRACT UniNARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ۾ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\)Other (Specify) 2 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred Hospitel or Attending 1 Natural 5 Pending 4 hours after death. Funerel Director: Af 2 Accident investigation 1 Yes 2 No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D 29a. Certifier 🛅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D54352 SEPTEMBER 8 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIRCEA TODOR HOSPITAL SHOT OLD COURT ROAD RANDAUSTOWN 21133 NORTHWEST MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2 2005

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Month Gail Marie Morten-McCoy September 8,2005 8:40 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3800 Woodbine Avenue Baltimore N/AIf Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2X F 49 217-64-6095 Yrs. Director 10,1955 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits in than "natural", or items 23a or 28a-f show the Medical Examinant be notified at 1XYes 2 ☐ No Director Maryland N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3800 Woodbine Avenue 21207 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than " Elementary/Secondary (0-12) College (1-4or 5+) 11th Grade Geriatric Nursing Asst. Ruxton Healthcare other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any injury or other treumatic event size. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harrison J. Morten Elizabeth Freeman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Angela M. Morten/ Daughter 2647 Loyola Southway Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 9/13/05 Woodlawn, Maryland 22. Name and Address of Facility Chatman-Harris FuneralHome 21. Signature of Funeral Service Licensee yanis eroy 5240 Reisterstown Road Baltimore, MD21215 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical mall Cell by Cancer SIV equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last ettending physicien and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
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9 Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) be detached the signed by Part II. Owner significant conditions contributing to feath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate 1 Yes 2 No 1 Yes Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 ☐ Yes 2 No esidence 6 Other (Specify) Certification: To this Manner of Death 1 Natural 2 Accident 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 5 Pending death. 1 ☐ Yes 2 ☐ No investigation filled in by the Director 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 within 24 hours a To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signa are and 29d. Date signed (Month, Day, Year) REENE STREET 31. Date filed (Month, Day, Year) ... State Registrar

		Registrar 1. Decedent's Name (First, M	liddle I ac	t)		06	rtificate of	Death	12	Date of Dea	eg. No. &	2005	3. Time of Deat
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			For State Registrar	State of Ma	-	epartme Certifica			nd Mental Hy		005 29	55
	Physici	an	1. Decedent's Name (First, Middle, Last) Merrick Maynard						2. Date of D Month	Day	3. Time of De Year 005 1:00 P	iath M
is i	/Media		4a. Facility Name (If not institution, give	street and number)		4b. C	ity, Town, or	Location of		4c. County of		M
		Ļ	Anne Arundel Med				Annapo der 1 Year	lis	4 Hrs. 8. Date of B	Anne A		
К	Funeral Director		5. Social Security Number 6. Security Number 152-92-2295	M 2 F 7. Age	9 (In yrs. last birth 48	rs. Monf		Hours	Min. (Month, D		9. Birthplace (State or Fo Country) Georgia	oreign
	ס		Usual Residence of Decedent		10c. City, Town				72191 20	, 1997	10d. fnside City L	Linia
	faryla fahov	5	MD rince G	oorge ! s		wie					1 🗆 Yes 2	
	the A	rect	10e. Street and Number	eorge 3	Do		Zip Code			10g. Citizen of W	haf Counfry?	
	th with	a D	12115 Tanglewood	Lane				207	715	US	SA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show pray injury or other traumatic avant, the Modical Examinar must be rotified at SORE.	by Funeral Director	11. Maritaf Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 f Yes, Give Year or Dates:			cedent of His specify Cubar s 2 No	spanic Origi n, Mexican, Specify:	n? (Specify Yes or N Puerto Rican, etc.)	Black	- American Indian, k, White, etc. white	
21215-0036	in 72 hou n *natura	Completed t	t5. Decedent's Edu (Specify only highest grad	cation		Decedent's U (Give kind of life. DO NO	Jsual Occupa work done d T use retired)	ition uring most	of working	16b. Kind of Bus	siness/Industry	
212	d with giene er the	Com	Elementary/Secondary (0-12) 12	5+)+)	h	ousewi	fe		own h	ome	
pu	be filed ital Hygir id other event, ii	Be	17. Father's Name (First, Middle, Last)	1					s Name (First, Middl		•)	
Maryland	should be fand Mental He marked of	2	Byron Manton Woo		19b.	Mailing Addr	ess (Street a		rgarite Ha		State. Zip Code)	
Ma	and 2 s eaith an n 27 ls i		William Maynard/sp						ne Bowie,			
Baltimore,	Pages 1 al nent of Hea int: If item iry or othe		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F 4 ☑ Donation 5 □ Other (Specify)		20b. Place of cemetery	Disposition (, crematory	Name of or other place	9)	Date	20c. Location - 0	City or Town, State	
Balti	permit. Departm Importa any inju		21. Signature of Foneral Service Licens Ronal of S.	lade, Dare	ctor	State	and Addres Anato more,	my Bo	ard 655 W	. Baltimo	re Street	
1	Physician /Medical Examiner	il Examiner	23a. hart1. Enter the dis se, comp shock, or heart fail re. List only of mmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	ne.	nog Cal		g, such as c	ardiac or respiratory	arrest,	Approximate Interval Betwee Onset and Dea IVI Dh	ath
P.O. Box 68760	that the death certificate be executed od by the attending physician and detached for use as the buriat transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	d	2 Fetal death	3 ⊟Ectop 5 ⊡ Other	c pregnancy (specify)			23d. Date Mon	e of delivery th Day Yea	ar
	w requires that been signed be should be det	þ	Part If. Other significent conditions co		uf nof resulting in	the underlyi	ng cause give	en in Part I.			ibute fo fhe cause of dea 3 Probably 4 Unk	
Il Records,	: The law requires that the cate has been signed by the page 2 should be detached	Completed							per	opsy p formed? d	Vere autopsy findings avarior to completion of cause eath? ☐ Yes 2☐ No	ailable se of
Vital	sicien certifi rector	Be	25. Was case referred to medical examiner?	Hospital:			Othe	ar.	of Death (Check only		(0	
Division of	iding Physith. Ih.: After this funeral di	tlon: To	1 ☐ Yes 2 Ø No 27. Manner of Death 1 Manual 5 ☐ Pending 2 ☐ Accident investigation	1 of fnpafie 28a. Date of Inju (Month, Da			28c. Injury Work	4 🗆 Nur		sidence 6 Othe how injury occurre		
Divisi	of or Atternation after dea	Certification:	3 Suicide 6 Could not be 4 Homicide determined	286. Flace of In	ury - At home, fai c. (Specify)	rm, street, fac	ctory, office		28f. Location City or T	(Street and Numbe own, State)	er or Rural Route Numbe	ir,
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has a completely filled in by the funeral director, page 2.	edical C	29a. Certifier 1 Certifying Phy (Check only one)	rsicien: To the best iner: On the basis o and manner st	f examination and	, death occur Vor investiga	red at the tim tion, in my op	e, date and pinion, death	I place, and due to the occurred at the time	e cause(s) and mar a, date and place, a	nner as stated. and due to the cause(s)	
)	To the within To the comp	Me	// (3	Buch,				4605		916	(Month, Day, Year)	
			30. Name and address of person who come address of p	ompleted cause of c	death (frem 23a) (Type, Print)	loukwe	y, a	mhapotil,	MO		
	St Regist	ate	31. Date filed (Month, Day, Year) SEP 1 2 2	32. B gistr	rar's Signature	Spers	W.					

	State of Maryland / Department of Health and 1- State Registrar Certificate of Death	Mental Hygie	2000 / 4001
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Christopher Melson 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea	August 27	Day Year 3. Time of Death 8:45 PM M
Funeral Director	Southern MD Hospital Clinton 5. Social Security Number 6. Sex 1 Months Days Hours Min 262-17-1881 Clinton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min	8. Date of Birth	
vith the Maryland or 28a-f show be notified at	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Prince George S Clinton 10e. Street and Number 10f. Zip Code	10g.	10d. Inside City Limits 1 ☐ Yes 2 ☑ No Citizen of What Country?
ours after death verified; or Items 238	9211 Stuart Lane 11. Marital Status unk 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, specify Cuban, Mexican, Pue 1 □ Yes 2 ☑ No Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of work disabled	orking 16b	USA 14. Race - American Indian, Black, White, etc. Specify: white . Kind of Business/Industry
Definitions, wally land X IXING Permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturany injury or other treumatic event, the Modical once. To Be Completed	19a. Informant's Name/Relationship (Type, Print) Southern MD Hospital 20a. Method of Disposition 1	inton, Mu Date 200	ty or Town, State, Zip Code) 20735 Location - City or Town, State
Physician /Medical Examiner	23a. P. 11. Enter the dilear complications that caused the death. Do not enter the mode of dying, such as coding ships, or heart failure. List only one cause on each line. Immediate ause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		Approximate Interval Between Onset and Death
v requires that the death certificate been signed by the attending physishould be detached for use as the lated by Physician/Medics	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year
2 8 8 1	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac 1 2 Yes 24a. Was an autopsy performed 1 1 Yes 2 1	
or Attending Physicien, or Attending Physicien, in prince death. Director: After this certific in by the funeral director. To Re-	examiner?	eath (Check only one) Home 5 ☐ Residence 28d. Describe how in 28f. Location (Stree City or Town, S	njury occurred t and Number or Rural Route Number,
To the Hospitel within 24 hours a To the Funeral I completely filled		curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s) Date signed (Month, Day, Year)
T 2 2 0	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8926 WC	sody an	812812005 CREC 55/01
State Registra	31. Date filed (Month, Day, Year) SEP 1 2 2005 SEP 1 2 2005	27	

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ORIGINAL

			1 - For State Registrar	State of Ma	ryland /	Departme Certifica	ent of H	lealth a	ınd Men		ene 2 0 0 !	29553
	Physici		1. Decedent's Name (First, Middle, Las	t)	N	litchu	~			Date of Death Month	Day 77 Year	- A : 104 14 14
	/Medic		4a. Facility Name (If not institution, give	street and number)		4b. Ci	ty, Town, or	r Location of		-J-mjosj	4c. County of De	
	Examin	er			6 cate		-	hmor			N/A	
	- Funeral Director		10 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age	fospital (In yrs. last bi	irthday) If Und Month	ler 1 Year	If Under 2 Hours	24 Hrs. 8. [Min.	Date of Birth Month, Day, Y	9. B 9.52 SOI	irthplace (State or Foreign Country) JTH_CAROLINA
	pu ,		Usual Residence of DecedenI 10a. State 10b. County		10c. City, Tov	m or Location						10d. Inside City Limits
	Maryla s-f ehov	ctor	MD. N/A		•	IMORE						1 XYes 2 No
	with the 3e or 28	i Director	10e. Street and Number 1828 W. BALTIMOF	RE, ST.		10f. 7	Zip C <i>o</i> de 2122	23		10g	. Citizen of Whal C	Country?
36	be filed within 72 hours after death with the Maryland its Hygiene. Its Hygiene. Other then "natural", or items 23e or 28e-f show event, I're Medical Examiner mant be notilised at	by Funeral	11. Marital Status Yan Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Tyes 20 No If Yes, Give A Year or Dates:		If Yes, s	cedent of H pecify Cuba 2 No	lispanic Orig an, Mexican, Specify:	gin? (Specify , Puerto Rica	Yes or No- n, etc.)	14. Race - Am Black, Wh Specify: BI	ite, etc.
1215-0036	ithin 72 hou ne. "natura nem "natura	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation		a. Decedent's U. (Give kind of life. DO NOT	sual Occup work done of use retired	ation during most d)	of working	16	b. Kind of Busines	s/Industry
Maryland 21	be filed ital Hygi d other event, I	To Be Co	17. Father's Name (First, Middle, Last)	=		GOOK			r's Name <i>(Fir</i> ZIE MI		iden Sumame)	
ary	s 1 and 2 should f Health and Mer Itsm 27 Is marke other treumatic	-	19a. Informant's Name/Relationship (7	Type, Print)	19	b. Mailing Addre	ss (Street	an d Number	r or Rural Ro	ute Number, C	ity or Town, State,	Zip Code)
	alth a alth a 127 ls		YVONNE TISDALE-N	AcGILL(SIST	CER) 1	544 N.	FORES	T PAR	K AVE.	BALTI	MORE, MAI	RYLAND 21207
Baltimore,	0 0		20a. Method of Disposition 1 ऄ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		cemete	of Disposition (A ary, crematory of LION CEM	r other plac	ca)	Date 9-13-2		c. Location - City of ALTIMORE	or Town, State MARYLAND
Balt	permit. Pag Depertment Important: I eny injury o gnce.		21. Signature of Francisco	JONATES,	D. HIB						NERAL HOM MORE, MAR	ME, P.A. RYLAND 21217
*	Physician		23a. Part I Enler the disease, or comp shock or heart failure. List only of Immediate Dause (Final	one cause on each line	Э.							Approximate Interval Between Onset and Death
4	/Medical Examiner		disease or condition resulting in death)	a. Acute Due to (or as a	consequence	of):	4 (nja	scho	7		Minutes
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Coron. Due to (or as a			di	sea	<u>se</u>			
1	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Lype	consequence							
8760	9 ys	cai	· ·	d. diase	100							
.O. Box 6	death certif e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at the 9 □ Unknown	Fetal deatl	h 3⊟Ectopic 5⊟ Other					23d. Date of de Month	elivery Day Year
۵.	signed by	ρ	Part II. Other significant conditions of	_	_	,	g cause give	en in Part I.			cco use contribute	to the cause of death?
Records,	sician: The law requires that the certificate has been signed by th riector, page 2 should be detache	Completed								24a. Was an autopsy performe	d? prior to	
ta			25. Was case referred to medical					26 Place		1 Yes 25	No 1 Ye	s 2 No
<u>=</u>	Physician: r this certific rat director.	o Be	examiner?	Hospital: 1 ☐ Inpatien	t 25 ERVO	utpatient 3	DOA Oth	05			e 6 ☐Other (Sp	ecify)
Division of Vital	ing Une Une	ation; T	27. Manner of Death Second	28a. Date of Injury (Month, Day	28b.	Time of Injury	28c. Injun Worl		28d.		injury occurred	
Divis		Certification;	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, f (Specify)	arm, street, fact	ory, office			Location (Stree City or Town, S		Rural Route Number,
	To the Hospital or within 24 hours afte to the Funeral Dir completely filled in	edical (29a. Certifier Check only one)	ysician: To the best of niner: On the basis of and manner state	examination a	e, death occurrend/or investigati	ed at the time on, in my of	ne, date and pinion, deat	d place, and o h occurred at	due to the caus t the time, date	e(s) and manner a and place, and du	as stated. se to the cause(s)
\	To the within 2. To the complet	Me	29b. Signature and title of certifier	ditens	Ly Ph	45.cm	29c. Licenso	e number	-/-	29d.	Date signed (Mor	74 Dous
	Δ		30. Name and address of person who	completed cause of de	ath (Item 23a)	(Type, Print)	J-00		40	H	fenusca	1 . 7065
	2		Marcia Cort, Mr	unus	22-	S. Once	ne St	reet ,	Balt	more.	MM 43	101
4	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 2	32. Registrar	's Signature			(
37	15 L		V41 4 6	LUUJ Allane	ue D	Sing.						

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** L. Poland Cedric /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Doctors Community Hospital Lanham If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 10**3** M 2 □ F Yrs. Director 40 1965 220-88-4419 Aug. 17, Wash. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other then "neturel", or iteme 23a or 28e-1 show other treumatic event, the Mudical Eval. Instrument be rediffical at 1 Yes 2 No Director Md. P.G. District Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6508 Foster Street 20747 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2X No Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Electrician Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Health and Mental I Myrtle Yates Roy T. Poland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6508 Foster Street District Heights, Dorothy M. Poland/wife 20747 Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State \$ = 6 1 Removal from State permit. Page Department of Importent: if any injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem. 9/6/05 Clinton, Md. 22 Name and Address of Facility Hodges & Edwards F.H. of Funeral Service Licensee 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part 1 Enter the disease, or complications that cause the death. shock, or heart failure. List only one cause on early ine. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a surresquence of): Physician/Medical Examiner The taw requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 🗌 Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 ☐ Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospitel or Attending 1 Natural 5 Pending after death. investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours after To the Funerel Di cai 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifier DOO14252 23a) (Type, Print) 32. Registrar SEP 1 2 2005

			For State Registrar	State of Marylar	nd / Depa <i>Cei</i>	artment rtificate	of He	ealth ar Death		neg	ene 2	005		955
).	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last Mosley Pate 4a. Facility Name (If not institution, give South River He	e street and number)	b Ctr.			Location of	Mon 8 Death		_	Year 05 ty of Death	3. Time of 2:20	pm ^M
Ī	Funeral Director		Social Security Number 6. Security Number			If Under 1		If Under 24	Hrs. 8. Date Min. (Mon	of Birth th, Day, Y	ear)		place (State	
	n the Maryland r 28a-f show	Director	Usual Residence of Decedent 10a. State 10b. County MD Anne Aru 10e. Street and Number		ty, Town or Lo	n Bur							l0d. Inside C	City Limits
36	J within 72 hours after death with the Maryland plens r than "natural", or Items 23a or 28a-f show the Medical Evant at must be notified at	by Funeral Dir	7885 Gordon Cour 11. Marital Status 1 Never Married 2 Married 3 M Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1			ent of His fy Cuban	21060 panic Origin , Mexican, I	n? (Specify Yes Puerto Rican, et		US 14. Ra	A ace - Americ ack, White,	can Indian,	
21215-0036	within 72 ene. than "nai	Completed b	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		16a. Deced (Give life. L	dent's Usual kind of work DO NOT use repai	k done du e retired)	tion uring most c	of working	16		Business/In	dustry	es
Maryland 2	should be filed ind Mental Hygis a marked other umatic event.	To Be (17. Father's Name (First, Middle, Last) Marion Franklin 19a. Informant's Name/Relationship (7)	Pate	19h Mailin	ag Addross (Ade1	s Name (First, A ine P。] or Rural Route I	Breed	an.	·	Codel	
ē,	ss 1 and 2 of Health a item 27 le r other tra		Emily Caldwell/ni 20a. Method of Disposition 1 Burial 2 Cremation 3 Company 4 © Donation 5 Other (Specify	ece marriage 20b.		untry	Clul	b Driv	ve Glen Date	Burn	ie, M		060	
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licen	Wade, Directo	r St Ba	Name and ate A	nato re,	my Bo MD 2	ard 655 1201	W. B	altin	ore S		
	Physician /Medical Examiner		23a. Pan1. Enter the disease, or com- shick, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		echac		or dying,	thru	Ardiac or respira	tory arrest			Approximation Interval Bei Onset and	tween
8/60,	certificate be executed adding physician end use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect c. Due to (or as a consect d.	,									
O. BOX 6	death certifi e attending ad for use as	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of of 9 □ Unknown	al death 3	Ectopic pre				_		ate of delive	•	Year
ords, P	w requires that the de been signed by the a should be detached f	by P	Part II. Other significant conditions of	ontributing to death but not res	sulting in the ur	nderlying car	use giver	n in Part I.	23e. 		cco use con 2 □ No	ntribute to th 3 □ Prob	ne cause of c	death? Unknown
	The law ate has b page 2 s	Completed	lailue	to the	lle				10		24b. d?] No	Were auto prior to cor death? 1 \(\text{Yes} \)	psy findings πpletion of a 2□ No	available ause of
_	ng Phys fter this ineral di	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury		Other c. Injury a Work?	Nurs		Residenc	e 6 Dti		/)	
DIVISION	oital or Attendurs after death aral Director: illed in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc. (Speci	fy) 				City	or Town, S	State)		l Route Num	iber,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Examone) 29b. Signature and title of certifier	ysician: To the best of my kniner: On the basis of examina and manner stated.	owledge, death ation and/or inv	estigation, i	t the time n my opi	nion, death	place, and due t occurred at the	time, date	and place,	anner as st and due to ed (Month,	the cause(s	;)
			30. Name and address of person who	Completed cause of death (Item	0	Print)	570 Not	28 A	tr. Ec	(0+)AIA	1/5/	105	,	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign	1100	harte	1701	w e	III CC	Jerva		/VII/		

				For State Registrar			of Mar	yland		artmen <i>tificat</i> e				lental Hy	giene Reg. No.	2005	100	
		Physici		1. Decedent's Name (First Arthur										2. Date of De Month Septer	Day	6, 2005	3. nnn na 12	
		/Medic Examir		4a. Facility Name (If not in			umber)			4b. City,	Town, or	Location	of Death	bepee.		County of Deat		
		LAGITI	iei	Upper Ch	nesap	eake Med	lica1	Cent	er	Ве	l Ai	r				Harfor	:d	
		Funeral		5. Social Security Number		6. Sex	7. Age (in yrs. lasi		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	rth ay, Year)	9. Birti Co	nplace (State or Fountry)	oreign
		Director		219-14-0496		1√2 M 2□ F		80	Yrs.					Oct 1,	1924	Mary	land	
		and and		Usual Residence of Dece 10a. State 10b.	County		1	0c. City, T	own or Lo	cation							10d. Inside City L	Limits
		ath with the Maryland 23a or 28a-f show	Į.	MD	Harfo	ord		Pτ	lesv:	i11e							1 ☐ Yes 2	
7			rec	10e. Street and Number	liallo	JI U			1031	10f. Zip	Code				10g. Citiz	en of What Co	untry?	
5		23a or	<u>=</u>	2122 Hark	ins H	Road					21	132				USA		
055		8 E	Funeral Director	11, Marital Status		12. Was De Armed F	cedent Eve	er in U.S.	13. \	Was Deced	lent of Hi	spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)	0- 1	4. Race - Ame Black, White		
O	98	to o	y Fu	1 Never Married 2		od 1 X Yes If Yes, G	2 □ No live			1 ☐ Yes		Specify:		1.10411, 010.7		Specify: wh	_	
	5-003	"natural",	d by	3 Widowed 4 C		Year or	Dates:	WWII										
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	212	s with piene.	Completed	Elementary/Secondary 12	(0-12)	College	(1-4or 5+)			ftsma					Hari	ford Co	Schools	
	פ	e filec Il Hyg othe vant,	BeC	17. Father's Name (First,	Middle, L	ast)				<u> </u>		18. Mothe	er's Name	(First, Middle				unk
6	<u>la</u>	wild b Ments wrked	To	Conrad Pot	t													
6/05	a	ges 1 and 2 should be filed within it of Health and Mental Hygiene. If itam 27 Is marked other than "to or other traumatic evant, It a Mus.		19a. Informant's Name/R						-						Town, State, Z	ip Code)	
3/5	2	of Health of Health litem 27		Marion Pot		ouse	1	COL Black				Road		esville		21132		-
5	Baltimore, Maryland 2121	Pages 1 ment of H ant: If ita ury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cre 1 ☑ Donation 5 ☐ 0	mation Other (Sp	ecify)		cem	e of Dispo etery, cren	sition (Nan natory or o	ne or ther plac	9)		Date	20c. Loc	cation - City or	Town, State	
	Balt	permit. Pages Department of important: If i any injury or once.		21. Signature of Funeral Roma	Service L	. Wade	W.	tor	St Ba	Name an ate A 1timo	d Addres nato re,	my B	y oard 21201	655 W.	Balı	timore	Street	
4		Physician		23a. Part1. Enter the dis shoot or heart failu Immediate Cause (Final disease or condition	ease, or o					er the mod	e of dyin	g, such as	cardiac c	or respiratory a	rrest,		Approximate Interval Betwee Onset and Dea	en ath
		/Medical Examiner		resulting in death)		b. Mel	Systo o (or as a o	consequen	nce of): -Cido!	si's,	Hy	pot	ensi	on.			24 Hour	٥.
281221		cuted nd ransit	Examiner	Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events	ns, ate					,	0						2 ment	٠ د ۸
281	ó	an an rial-tr	Exa	resulting in death) Last			ev Ca o (or as a o										_	
H	68760,	certificate be executed iding physician and ise as the burial-transit	edical			d. Ne	fasta	astatic NON-small cell Lung Cance							er. 9 months			
	.O. Box	that the death certifica led by the attending ph detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent preg in the past 12 monti 1 Yes 2 No 9 Unknown			birth 2 i	Fetal de	ath 3	Ectopic pro Other (sp.					2	3d. Date of deli Month	very Day Yea	ır
	<u>a</u>	\$ F 0		Part II. Other significant Hypothyr			death but r	not resultir	ng in the ur	nderlying c	ause give	en in Part I			tobacco us		the cause of deat	
	OS.	> 0 70	ojete	Cancer										24a. Was	an	24b. Were au	opsy findings ava	ıılable
20	Vital Records,	The ate h page	Completed by											1 Tes	2 No	prior to death? 1 ☐ Yes	ompletion of caus	se of
T	Κ		o Be	25. Was case referred to examiner? 1 ☐ Yes 2 ▼ No	medical	Hospital:	Inpatient	20/50	/Outration	t 3 🗆 DO	A Othe	VP		(Check only		T0** (0	7.1	
Ar		fter free	tion; To	27. Man or of Death	Pending	28a. Date (Mo	of Injury oth, Day Y		Bb. Time of Injury		8c. Injury Work	4 🗆 140	2	28d. Describe		Other (Spec	iry)	
#	Division of	To the Hospitei or Attanding within 24 hours atter death. To the Funeral Director: After completely tilled in by the fune	Certification;	2 ☐ Accident 3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could no	at bo	e of Injury ding, etc. (- At home Specify)	e, farm, str	eet, factory			-	28f. Location (City or To		Number or Ru	ral Route Number	ζ,
00		Mospite 24 hours Funarai etely tilled	edical C	29a. Certifier (Check only one)	Certifying Medical E	Physician: To the xaminer: On the and ma	ne best of r	camination	dge, death and/or inv	occurred vestigation,	at the tim in my op	e, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)	
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						180	~	>		I	>00	184	24		SEPT	T-6-	2005	•
				30. Name and address of B. PAREK	H M	D , 196	18 1	th (Item 23 HARL	Ba) (Type,	D-:-4\						21047		
		Sta Regista		31. Date filed (Month, B	EP 1	2 2005 32.	Redistrar's	Signature	y A	goods								

			State of Maryland / Department of Health and M	=	_	•					
			1 - For State Registrar Certificate of Death		eg. No. 201) E 0 0 = = -					
	Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of Deat Month		3. Time appliant					
	/Medic Examin	al	4a, Facility Name (If not institution, give street and gumber) 4b. City, Town, or Location of Death	09	4c. County of De	ath					
	LAdmin	iei	Catonsin le Commons Catonsin	lle	Bal	1 more					
	Funeral Director		5. Social Security Number 6. Sex 1 M DF 7. Age (In yrs. last birthday) 1 If Under 1 Year T Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. E	Sirthplace (State or Foreign Country) Loubana					
	D		Usual Residence of Decedent	12-21.	-20 /1						
	Aarylar f ehow	ō	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ es 2 ☐ No					
	r 28a-	rect	10e. Street and Number 10f. Zip Code	11	0g. Citizen of What	Country?					
	ath with	Funeral Director	1908 MONUMENTAL AVENUE 21227		USA						
	items Items	nne	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 10 No	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, W	merican Indian, hite, etc.					
21215-0036	be filed within 72 hours efter death with the Maryland ital Hyglene. d other than "neturel", or liems 23a or 28a-f e how event, the Medical Exactinar must be notified at	þ	If Yes, Give 1 ☐ Yes 2 ☐ No Specity:		Specify: U	Uhite					
5-0	"natu	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use refired)	ring	16b. Kind of Busine	ss/Industry					
212	d within	ошо	Elementary/Secondary (0-12) College (1-4or 5+) Home maker		OWN	Home					
	be filed tal Hygi d other	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, M	Maiden Sumame)	Tuck-e					
Maryland	should nd Men marka umaric	ည	John Henry Moreland Nanh Mann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura			Tucker					
	and 2 sho selth and n 27 le m		Rodney Eugene Reeves - SON 1908 Monumental N	d .							
Baltimore,	oth and the		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City						
III III	permit. Pages Department of Importent: If It any injury or o		"4 Donation 5 Dother (Specify) GREEN HORNT CEMERRY 9/10	105	Balto, 1	MO					
Ba	permit. Departr importe any inji		Frater I word 12134 willow	SDrive	Rd.	Home, P.A.					
4			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death					
1	Pnysician /Medical	6 13	Immediate Cause (Final disease or condition resulting in death)			norts					
	Examiner		Due to (or as a consequence of):			M					
	sit ad	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):								
V	le be executed ysician and e burial-transit	Examiner	Coase (Cise see of true) that intitlated events resulting in death) Last Due to (or as a consequence of):								
760,		cai	d								
x 68	death certifica e attending ph id for use as th	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		1						
Вох	death of attended for us	by Physician/Med	1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Ves 2 Fetal death 5 Other (specify)		23d. Date of delivery Month Day Year						
P.0.	thet the de led by the a detached t	hys	9 ☐ Unknown								
	The law requires thet the ste has been signed by the bage 2 should be detache		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			to the cause of death? Probably 4 refinement					
Records,	w requ	lete	DM II	24a. Was a	n 24b. Were	autopsy findings available					
Re	The lav	Completed	Mx Colon Concer	autops perform 1 Yes 2	ned2 death	to completion of cause of ? es 2 \(\sum No\)					
Vital	iclen Sertifi ector	Be	25. Was case referred to medical examiner? Hospital: Other.	th (Check only on							
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ion	anding ath. or: Afte	atlo	2 Accident investigation M 1 Yes 2 No								
Division	or Attendenter de Directorin by the	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St. City or Town		Rural Route Number,					
	To the Hospitel or Attending Phys within 24 hours eiter death. To the Funerel Director: After this completely filled in by the funeral director.		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the ca	ause(s) and manner	as stated.					
	the Ho nin 24 I the Fu ipletely	ledical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	red at the time, da	ate and place, and o	lue to the cause(s)					
	To To corr	Σ	29b. Signature and title of certifier 29c. License number 29c. License number	7	9d. Date signed (Mo	onth, Day, Year)					
	,	14	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) B. Walthy M. 1009, Frederick Rd. Coffee	J 110	47, V	20					
	Le			75 64 /	- カムノム	- 3					
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 2 2005								
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			1 - For State of Ma	aryland / Depa	artment of H		ental Hyg	iene _{eg. No.} 2005	29558	
	Physici /Medio	cal	Decedent's Name (First, Middle, Last) Osborn Aquilla Rawlings S	r			2. Date of Death Month August	Day Year 29, 2005	3. Time of Death / 8/, 50 /9 //	
	Examir	ier	4a. Facility Name (If not institution, give street and number) 11 Pearl Drive		4b. City, Town, or Location of Death Port Deposit 4c. County of Death Cecil					
Ĭ.	Funeral Director		5. Social Security Number 6. Sex 7. Ag 19-16-8411	e (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb 9, 1	00=	hplace (State or Foreign untry) yland	
	the Maryland 28a-f show	Director	10a. State 10b. County MD Cecil 10e. Street and Number	10c. City, Town or Lo			11	0g. Citizen of What Co	10d. Inside City Limits 1 Yes 2 No	
d 21215-0036 filed within 72 hours after death with the Maryland	should be filed within 72 hours after death with the Marylan nd Mental Hygiene. marked other than "natural", or Items 23a or 28a-f show imatic event. It e Madical Examinar must be notified at	Funeral	11 Pearl Drive 11. Marital Status 1 □ Never Married 2 ▼ Married 1 ▼ Yess 2 □ I	No l	Was Decedent of Hi f Yes, specify Cubar			USA 14. Race - American Indian, Black, White, etc.		
	ithin 72 hours ne. nen "natural", nen "cal Exal	Completed by	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5)	16a. Deced (Give life. I	1 ☐ Yes 2 ▼ No dent's Usual Occupa kind of work done a DO NOT use retired, ack driver	turing most of worki)	ng		Specify: white 6b. Kind of Business/Industry	
and 21	d al d	Be	10 0 17. Father's Name (First, Middle, Last) Asbury Aquilla Rawlings		transporta Maiden Surmarne)	tion				
Maryi	0 00 00	안	19a. Informant's Name/Relationship (Type, Print) Maria Smith/daughter		ng Address (Street a	and Number or Rura	l Route Number,	City or Town, State, 2	ïp Code)	
altimore, Maryland 2121	m O		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State '4 ☒ Donation 5 □ Other (Specify)	20b. Place of Dispo			-	20c. Location - City or	Γοwπ, State	
Balt	permit. Page Department of Important: If any injury or once.		Jonay // Court	Ba	ıltimore,	MD 2120	L	Baltimore		
A ST	Frysician /Medical		23a. Palt1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each liming the cause (Final disease or condition resulting in death) Due to (or as	a nsequence of):	er the mode of dying	g, such as cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death	
8760,	ate be executed by sician and hysician and ithe burial-transit	dicai Examiner	cause. Enter Underlying Cause Classes or injury that initiated events c.	a consequence of):						
O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli-	very Day Year	
ecords, P	w requires that been signed b should be dete	by	Part II. Other significant conditions contributing to death b	ut not resulting in the u	nderlying cause give	on in Part I.		acco use contribute to s 2 □ No 3 □ Pro	the cause of death?	
Vital Reco	The ate h	Completed					24a. Was ar autopsy perform 1 Yes 2	prior to c death?	topsy findings available ompletion of cause of	
Ö	iing Phys h. After this funeral di	ertification; To Be	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	nt 2 ER/Outpatien y y 28b. Time of Injury	28c. Injury Work	26. Place of Death 1. 4 □ Nursing Hor at ? (es 2 □ No	ne 5 ⊠ Residei	ance 6 ⊡Other (Spec w injury occurred	īfy)	
Division	ital or Attenous after death	O	4 Homicide Solomines building, etc				City or Town,			
	To the Hospital or within 24 hours after to the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of and manner start 2 Medical Examiner: On the basis of and manner start 29b. Signature and tille of certifier							
			I fasher, MD		D 15	3/4	A	Lugust 30	2005	
	Sta	- 10	31. Cate filed (Month, Day, Year) 32. Registro	eath (Item 23) (Type, On 5	Mern C	The say .	enke H	ospice :	Day, Year) 2005 FIKTSu, M	
	Registr	ar	SEP 1 2 2005	ence H.	Coorlis					

				For State Registrar	State of Mar	yland / De <i>C</i>	partmer <i>ertifica</i> :	t of Heal	lth and M <i>ath</i>		jiene 2 eg. No.	2005	29559	
		° Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Dea Month		Year	3. Time of Death					
		/Medic	cal	Myers Rodgers 4a. Facility Name (If not institution, give str	not and oumber)		4b Ciby	Town, or Loca	ation of Dogth	August		2005 ounty of Death	11:10 AM	
		Examir	ier	Joseph Richey H				altimor			46.00	ounty or Death		
		Funeral		5. Social Security Number 6. Sex	7. Age ('In yrs. last birthda		r 1 Year If U		8. Date of Birth (Month, Day	Year)	9. Birthp	lace (State or Foreign	
		Director		218-60-4605	1 2□F	52 Yrs	·	Days		Apr 5,		Mary]	**	
		land ow		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or	Location					1	0d. Inside City Limits	
		ilied within 72 hours after death with the Maryland Hygiene. ther then "naturel", or Items 23a or 28e-f show int, the Medical Evain, or must be notified at	tor	MD		Baltim	ore						¹∏Yes 2□No	
		or 28	Director	10e. Street and Number			10f. Zij	Code		1	0g. Citize	n of What Coun	itry?	
		s 23g		828 N. Eutaw Stree	t. Was Decedent Eve	or in II C 4		21201	in Origina (For	ait. Van an Na	USA Race - Americ	an Indian		
210	'	fter de	Funeral	11. Marital Status 12 1 ☑ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No				exican, Puerto	ecify Yes or No- Rican, etc.)	14.	Black, White,		
1/4	93	ours a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2∏ No Sp	ecify:	Specify: 1			ck	
7.	<u>5</u>	"natu	letec	15. Decedent's Educa (Specify only highest grade of	tion completed)	(G		al Occupation ork done during	g most of worki	unk ing	16b. Kind	of Business/Inc	dustry unk	
B	212	e filed within al Hygiene. other then ' vent, Ills Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	s. DO 1401 a	30 1011100/						
	and	a = 0 \$	Be C	17. Father's Name (First, Middle, Last)						(First, Middle, I	Maiden Su	ітате)		
13/	Yla		2	Myers Rodgers					Clara Ti					
76	Mai	id 2 sh th and 27 is n treun		19a. Informant's Name/Relationship (Type, Print) James Hargrove/brother 19b. Mailing Address (Street and Number or Rural Route Number, 216 Douglas Court Baltimore,								MD 21231		
_	Je,	ss 1 and of Health Item 27		20a. Method of Disposition	20b. Place of Dis	sposition (Na		0	Date	20c. Loca	tion - City or To	wn, State		
5	Ē	Pages ment of ent: If It ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rer `4 ☐ Donation 5 ☑ Other (Specify)	1									
Davide	Baltimore	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 is marked any injury or other treumatic evonce.		21. Spuriore of Funeral Stryice Licensee RTIAL d. S. W.	distrect				Facility Board 2120	655 W.	Balt:	imore S	treet	
177		¥		23a. Part1. Enter the disease or complica shock, or heart failure. List only one	tions that caused th cause on each line.						est,		Approximate Interval Between	
		Physician		Immediate Cause (Final disease or condition resulting in death)	Acquired	Immune	Defic	ency S	yndrox	ne_			Onset and Death	
		/Medical Examiner		resulting in douting	Due to (or as a c	consequence of):								
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		The faw requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events c. Due to (or as a consequence of):										
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\sim	9	tificate ig phys as the	edical	d										
er	Box	attending for use as	an/M	230. was decedent pregnant	. If yes, outcome of 1□Live birth 2 {		3 □Ectopic p	regnancy		23d. Date of delive				
DC	0	that the dea ed by the at detached fo	by Physician/M	in the past 12 months? 1								Month	Day Year	
20	ر. م.	es that thighed by be detact	y Ph	Part II. Other significant conditions contri	buting to death but r	not resulting in the	underlying o	ause given in	Part I.	23e. Did tobacco use contribute to the cause of death?				
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RS	al Records,	a taw r has be	Completed							24a. Was a autops	v	24b. Were autor prior to con	osy findings available npletion of cause of	
(F)	a									perform		death? 1 ☐ Yes	21 No	
2	₹	Physicien: The true this certificate harral director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	pital:	2 ER/Outpat	ient 3 DC	Other	-	n <i>(Check only on</i> me 5 ☐ Reside		Other (Specif	tospice	
	n of	ng Ph fter th neral	J : uc	27. Manner of Death 1. Natural 5 □ Pending	28a. Date of Injury (Month, Day Y	28b. Time	of 2	8c. Injury at Work?		28d. Describe ho			1001	
	Division	Attending r death. sctor: After by the fune	catio	2 Accident investigation 3 Suicide 6 Could not be	an Diversión		М	1 🗆 Yes		206 1 (04				
	Σ	after after Direction by	Certification:	4 Homicide determined	28e. Place of Injury building, etc. ((Specify)	street, factor	/, office	-	28f. Location (St. City or Town	reet and N , State)	iumber or Hurai	Houte Number,	
		To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one) Certifying Physic 2 Medical Examine	ian: To the best of r	kamination and/or	eath occurred investigation	at the time, da , in my opinion	ate and place, a	and due to the ca	ause(s) an ate and pla	d manner as sta ace, and due to	ated. the cause(s)	
		To the within To the Comple	Me	29b. Signature and title of certifier				. License num				igned (Month, L		
				1 Com				241	70		Aug	ust 23,	, 2005	
				E.TSOMD Ric	pleted cause of deal	ce 838	Print) NE	utar!	st 7	3altim	ere	MD 2	,2005 1201	
		Sta Registi		31. Date filed (Month, Day Year) SEP 1 2 20	32. Redistrar's	Signature	Coul	'						

State of Maryland / Department of Health and Mental Hygiene 2 29560 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) $\overset{\text{Day}}{2}005$ Sept 5, **Physician** 9:00A Charles Lloyd Simmons /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's 55 Akin Ave Capitol Heights, If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | Min. | Min. | March 27, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 ₩ 2 □ F 1940 CLinton, MD Yrs. 213 40 8074 65 **Director** Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Exerciner must be notified at Capitol Heights 1 ☐ Yes 2 XXIo MD Prince George's Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 55 Akin Avenue 20743 United States or Items 23a Funeral Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Inportant: If tiem 27 is marked other than "natural", or Iten any injury or other traumatic event, Ite Medical Exaction once. 1 ☐ Yes 2 ☑ No If Yes, Give XX Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 _{Specify:}African American 1 ☐ Yes 2√√No Specify: δ 3 Widowed 4 XX ivorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Food Industry Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Katherine R. (Unknown) Doctor Lloyd Simmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 55 Akin Ave, Capitol Heights, MD 20743 Jacqueline Pinnex (POA) 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept 13, 2005 20a. Method of Disposition 20c. Location - City or Town, State 1 X urial 2 Cremation 3 Removal from State Resurrection Cemetery Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 01d Alexandria Ferry Road, Clinton, MD 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician Vinua Disease Human Immunodeficercy disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🔲 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical ro the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ampay Loaver D16619 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOWKE DR. BAYTIMORE, M.D. 21236 9940 FRANKLIN C. VERGARA-SOARES 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 1 2 2185 State of Registrar

Kemp Smith 05-05967 RPD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registramend Item 1& 1. Decedent's Name (First, Middle, Last)	Unpend Ite	em 23a, 27	ejitisate pe	Deneth G84	8 10-13-0	5. NE 26 0 0 5	29561			
	Physici		Kemp Lee Edgar	Smith,	II.			Month Septemb	Day Year				
	/Medio Examir		4a. Facility Name (If not institution, give s	treet and number)			or Location of Dea		4c. County of Deat				
			Sinai Hospital		2	Baltime			N/A				
	Funeral Director			M 2DE	(In yrs. last birthda Yrs.	Months Days			, Year) 9. Birt 1951 N.	hplace (State or Foreign buntry) Carolina			
9	and		Usuat Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits			
	Maryland I-f ehow filed at	tor	Maryland N/A		Balt	imore				1 XYes 2 No			
	death with the Marylan me 23e or 28e-f ehow Email be rediffed at	ai Direc	10e. Street and Number 4144 Fallstaff	Road		10f. Zip Code 21	215	1	USA	untry?			
920	after dea or iteme	d by Funeral Director	11. Marital Status **Mever Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent E Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		3. Was Decedent of ff Yes, specify Cu 1 ☐ Yes 2 ☑ No		n, Puerto Rican, etc.)		Race - American Indian, Black, White, etc. Decify: Black			
21215-0036	s 1 and 2 should be filed within 72 hours if Health and Mental Hygiene. Item 27 ie marked other then "neturel; other traumatic event, I'm Medical Exp	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+	(Gi life	cedent's Usual Occi ve kind of work don . DO NOT use retir	e during most of wo red)	orking	16b. Kind of Business/	nd of Business/Industry			
ם א	Hygi other	(D)	12th grade 17. Father's Name (First, Middle, Last)		U1.	employe	18. Mother's Na	ner's Name (First, Middle, Maiden Sumame)					
lan lan	should be id Mental marked matte ev	To B	Kemp Lee Edgar	Smith, S	Sr.		Betty	Smith					
Maryland	and M		19a. Informant's Name/Relationship (Ty)				r, City or Town, State, 2						
	of Health Item 27 i		Maxine Garland-	Bey/ Sis	A CONTRACTOR OF THE PARTY OF TH			Control of the second		yland21215			
Baltimore,	permit. Pages 1 a Department of He Important: if Item eny injury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State		position (Name of rematory or other pl emorial			20c. Location - City or Woodlawn,	Town, State Maryland			
Balt			21. Signature of Funeral Service License	e An	15	22. Name and Add	ress of FacilitCha stersto	atman-Ha wn Rd Ba	arris Fun altimore,	eral Home Md 21215			
		2	23a. Part1 Enter the disease, or compli- shock, or heart failure. List only or	cations that caused to e cause on each line	he death. Do not e	enter the mode of dy	ring, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death			
	/Medical Examiner prize	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	on)									
P.O. Box 68760,	The law requires that the death certificate be execut te has been signed by the attending physician and tage 2 should be detached for use as the burial-tran	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	су	-	23d. Date of def Month	defivery Day Year					
	quires that n signed b uld be dett	by	Part II. Other significant conditions con	tributing to death but	t not resulfing in the	underlying cause g	given in Part I.		23e. Did tobacco use confribute to the cause of d				
Division of Vital Records,	. 40 0	Completed						24a. Was a autops perform	sy prior to o	Were autopsy findings available prior to completion of cause of death? ▼S 2□ No			
Vita	ician: T certifical rector, p	Be	25. Was case referred to medical examiner?	ospital:				ath (Check only on	ne)				
on of	ding Phys h. After this funeral dii	tion: To	1 X Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Oate of Injury Found, Day 8-31-05	28b Time	of 28c. Inj			ence 6 □Other (Spec ow injury occurred U	nk			
Divis	2 # 2 # 2	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injurbuilding, etc.	Э	28f. Location (Street and Number or Rural Route Number, City or Town, State) 3402 Virginia Ave Baltimore, Md							
	To the Hospitel , within 24 hours a To the Funeral C completely filled	Medical	29a. Certifier to Certifying Physical (Check only one)	ician. To the best of ter: On the basis of and manner stat	examination and/or	aili occurred at the investigation, in my	ilme, date and place opinion, death occ	e, and due to the caurred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)			
	To the within 2 To the comple	Me	29b. Signatore and title of certifier	und mainier Stat	ou.	29c. Licer	nse number	2	9d. Date signed (Monti	h, Day, Year)			
	1		> and 2			0.0	C.M.E.	September 1, 2005					
7	John Y		30. Name and address of person who co		ath (ftem 23a) (Typ 111	Penn Stre	eet, Balt	imore, Ma	ryland 212	01			
6	Sta Regista		31. Date filed (Month, Day, Year) SEP 1 2 20	32. egistra	r's Signature	books							

State of Maryland / Department of Health and Mental Hygiene 2 29562 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Year **Physician** 05510 6.45 Am abron eptenter 2005 /Medical 4c. County of Death 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth **Examiner** aldimore romivell 7. lige (In yrs. lest birthday)
Yrs. Social Security Number 6. Sex / 102 M 2□ F If Under 1 Year 8. Date of Birth (Month, Day, Yeer) Birthplece (State or Foreign Country) **Funeral** Months Days Hours Director 239 · 12 · 4667 10a. State 10b. County 10c. City, Town or coation 10d. Inside City Limits Departmant of Health and Mental Hygiene. Important: jor items 23s or 28e-4 ehov important: if item 27 is marked other than "naturel", or items 25s or 28e-4 ehov any injury or other traumatic event, the Medical Examiner mast be notified at PACTIMORE 1 Ves 2 □ No MDBe Completed by Funeral Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6614 LOCH RAVEN 2/239 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 207No 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry FOOD Elementary/Secondary (0-12) College (1-4or 5+) CUHER MEAT 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) LOCH BLVD RAVEN DAUGHTER 20a. Method of Disposition
1 Derivation 2 Cremation 3 Removal from State 20b. Place of Disposition (Neme of cemetery, cremetory or other place) CEMETERY 9.10:05 ARBUTUS MARYLAND
22. Name and Address of Fecility VAVOHN C. EXEENE FUNERAL HOME 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 4905 YORK ROAD BAUTIMORE, MARYLAND 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es a consequence of Physician/Medical Examiner ed by the attending physician and detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ģ erai Director; After this certificata has been si fillad in by the funeral director, page 2 should i Be Completed 24a. Was en autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 21410 TL Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To AUNursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Naturel 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No after death. investigetion 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier Medicai 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signature end title of 29c. License number uhr, MD D9059853 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Baltim 5601 och 1 2 2005 32. Registrer's Signature State Registrar

Physician /Medical **Examiner**

Funeral

with the Maryland

Director ral, or items 23a or 28e-f show Examiner must be notified at Direct Funeral ð Completed or other treumatic event, the Medical

Pages 1 and 2 should be filed within 72 hours after death venent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23s Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tree 21. Signature of Funeral Service Licensee unice Immediate Cause (Final disease or condition resulting in death) CARDIAC ARRHYTHMIA Physician FATAL /Medical Due to (or as a consequence of): **Examiner** INFARCTION MYOCARDIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9☐ Unknown 9 Unknown I signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed been certificate has page 2 Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 🕱 No Certification: To 2XER/Outpatient 3 DOA s after dea... est Director: After ... 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of To the Hospitel or Attending 5 Pending 1 XNatural investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 - Homicide Within 24 hours To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medicai (Check only one) and manner stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID JACOBS 3001 -HOSPITAL DRIVE 31. Date filed (Mogt edistrar's Signature State 2005 Registrar DHMH 17 Rev 1/2001

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 2005 5:24B 4, September Edward J. Tabor 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Cheverly Prince Georges Prince Georges Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Yea 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 1**∑**tM 2□ F 77 Yrs. ΫÄ 579-34-4216 Feb.4, 1928 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits P.G. 1 Yes 2 No Md. Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #341 20744 United States 6801 Bock Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates: Black 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 Driver Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Nathaniel Tabor Altha B. Bennett 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6801 Bock Road #341 Fort Washington, Maryland 20744 19a. Informant's Name/Relationship (Type, Print) Mildred P. Tabor/wife 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ⊠Burial 2 □ Cremation 3 □ Removal from State * 4 □ Donation 5 □ Other (Specify) 9/9/05 Lincoln Cem. Brentwood, Md. 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23d. Date of delivery

> 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Was an autopsy performe 2 X No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 XNo

Day

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2005 29564 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 08 01 9:25 P. M **Physician** Tuckson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville Montgomery Casey House If Under 1 Year If Under 24 Hrs. 8.
Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🖾 F 88 South Carolina 578-20-3590 19 17 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show other traumatic event. The Medical Examinar must be notified at tx☐Yes 2☐No Washington D.C. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20017 USA 3927 9th. Street N.E. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours afternent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Ite 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: Black Specify. Baltimore, Maryland 21215-0036 þ 3 Midowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Domestic 12th. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Louise Jenkins Lemuel Jamison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 42 Dalamar St. #4 Gaithersburg, MD. 20877 Wendell Tuckson/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition it of ... 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 8-9-05 Brentwood, MD. Fort LIncoln Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licensee 4217 9th. St. N.W. Washington, D.C. 20011 may Approximate Interval Between Onset and Death 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final months Physician Renal Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner years Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760, nding physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) o 9 Unknown s been signed by t should be detach ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 🔀 No certificate 1 Yes To the Hospital or Attending Physician: 26. Place of Death Check onl. one director, 25. Was case referred to medical Be examiner Other: 4 Nursing Home 5 Residence 6 COther (Specify) Hospice Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? funeral 27. Manner of Death After 1 Natural Division 5 Pending 1 ☐ Yes 2 ☐ No M after death. 2 Accident investigation illed in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified September 10, 2005 D42452 impleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who of Rockville, MD. 20850 Chitra Rajagopal 6001 Muncaster Mill Road 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 005 29565 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Edmonia V. Tucker 28, 2005 1336 Aug. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 □ F 217-20-9769 94 14, 1911 Virginia Director Jan. Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at 1 Yes 2 □ No Director Baltimore Maryland N/A10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 524 N. Charles Street #1204 USA 21201 Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or item ony injury or other traumatic event, the Market 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specia Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) Private family Elementary/Secondary (0-12) College (1-4or 5+) Domestic 8th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lottie Greenhill Stith Tucker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type Print) 1333 Shepherd, N.W. Washington, D.C. 20011 George Spicely/ Nephew 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 9/8/05 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitChatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 21. Signature of Funeral Service Licensee 23a. Part) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical terio Sclero Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed as the burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medicai IE EEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 Live birth Day Yea Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown been signed by the should be detached Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical 26. Place of Death [Check only one] Be examiner Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Dther (Specify) 1 Yes 2 No ၉ 2 ☐ ER/Dutpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the 1 after death 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Płace of Injury · At home, farm, street, factory, office building, etc. (Specify) illed in by 4 Homicide To the Hospital within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D16376 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre ical Atwy, 31. Date lied (Month, Day, Year) 2001 med State Registrar 2005

State of Maryland / Department of Health and Mental Hygiene For State Registra 29566 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day September 3:55 AM Joseph otta 12 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Medical Baltimore n/a If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 1⊠M 2□F Yrs Nov7,192 Director 711-07-5709 83 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location rel', or Items 23a or 28e-f show Examiner must be notified at 10d. Inside City Limits Md. n/a Baltimore M∑Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 314 South Exeter Street 21202 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after or and Mental Hygiene. 1 TYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ Specify: White 3 ☐ Widowed 4 ☐ Divorced "neturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) 7th Baggage Handler Amtrak 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be marked Anthony Votta Amelia Iannio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 I Frances Votta (wife) 314 South Exeter St. Baltimore, Md.21202 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If It any Injury or o ŏ ^¹ 4 □ Donation 5 □ Other (Specify) Most Holy Redeemer 9/16/2005 Baltimore, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore, Md 21222 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final **Physician** failure disease or condition resulting in death) respiratory /Medical Due to (or as a consequence of) Examiner lung cance Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as consequence of) Examine physician and the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medicai as the esn IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 □Ectopic pregnancy jo in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. I ed by the a detached f 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ been sig 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed 1 ☐ Yes 2 No 2□ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this After the 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Hospitel or Attending 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie Medical within 24 ho To the Fune completely f (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 85 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Maryland 21201 22 South Greene Street 32. Ranstrar's Signature 31. Date filed (Month, Day, Year) State 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician Eldred** Westry August 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LORIED (a RWERSIde If Under 1 Year If Under 24 H XOC 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Firthplace (State or Foreign Country) N. Carolina **Funeral** Min Days Hours 246-30-2540 Director 19 1925 80 Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location worle 10d. Inside City Limits r than "netural", or items 23a or 28e-f eho the Madical Examiner is ust be natified at N/AMaryland Baltimore 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 USA 3914 Eirman Avenue 12. Was Decedent Ever in U.S. Armed Forces?

XXYes 2 No
If Yes, Give Korean
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Black Maryland 21215-0036 1 ☐ Yes 2 ☐ No ۵ Specify: 3 Widowed 4 Divorced Completed Era 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Moulsdale Trucking al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver 9th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be fi Health and Mental H tem 27 is marked otl Inez Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3914 Eierman Ave Baltimore, Maryland 21206 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 ment of Health a Louise Westry/ Wife injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 9/8/05 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of finbortant: if any injury or Harford Memorial n Memorial Gar. Aberdeen, Maryland 22. Name and Address of Facility Chatman-Harris Funeral Home *4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Experal Service Licensee, 5240 Reisterstown Rd Baltimore, Md 21215 Inter the divease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a, Part1 Approximate Interval Between Onset and Death disease or condition resulting in death) Physician) ee /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical use as the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) Ö been signed by the should be detached 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 ☐ Yes 247No Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? has certificate me 1 Yes 25 No of Vital 2 No 1 Yes i or Attsnding Physician: after death. Director: After this certifica To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Tyes 2. No 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ☐ ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 🖰 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) th (Item 23a) (Type, Print) 30. Name and address of person who completed cause of anne 31. Date filed (Month, Day, Year) 32. Reg State SEP 1 2 2005 Registrar

DHMH 17 Rev 1/2001

r Print in Black Indelible Ink. Ensure All Copies Are Legible. of Maryland / Department of Health and Mental Hygiene Amend item/9 perFH G847 Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 06: 10AM Shirley Wilson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 7. Age (In yrs. last birthday) If Under 24 Birthplace (State or Foreign Country) 5. Social Security Number 6 501 Date of Birth (Month, Day, **Funeral** Year) Min Months Hours 1 □ M 2 □ F 578-56-5271 62 August 27, 1943 Roxboro, NC Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d Inside City Limits 10b. County r then "naturel", or iteme 23a or 28a-f show the Medical Examinar must be notified at MD Prince George's Capitol Heights 1 No Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6500 Central Avenue Apt# 1 20743 United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 INO Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages t and 2 should be filed within 72 Department of Health and Mental Hygiene. important: If item 27 is marked other then "nateny injury or other traumatic event, the Medica one. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Colfege (1-4or 5+) Truck Driver Trucking Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Leroy Smith Geraldine Paylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1013 Epworth Way Capitol Heights, MD 20743 Tyra Paylor (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 to Burial 2 ☐ Cremation 3 ☐ Removal from State 9/15/2005 Brentwood, MD Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Mc 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Road Brenwood, MD 20722 non II 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Metastatic Immediate Cause (Final disease or condition resulting in death) RMINAL Endonetrial Physician 6 months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Dunknown Shipley A-Wilson cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 24a. Was an autopsy 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ↑ ✓ Inpatient 2 ☐ ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending fniury Vaturat 5 Pending investigation M 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral D Contrying Physician. To the best of my knowledge ideath occurred at the time, date and blace, and due to the nause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 23a Conflict Medical (Check only one) completely and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of o death (Item 23a) (Type, Print) 30. Name and address of pers in VL ESQUI 31. Date filed (Month, Day, Year) 뤔 gistrar's Signature State 1 2 2005

DHMH 17 Rev 1/2001

Registrar

		For State Registrar	State of Maryland	d / Depa <i>Cer</i>	artment of F	lealth and I Death	Reg	ene 200	5 29569		
Physicia		1. Decedent's Name (First, Middle, Last HARVEY)		WEIST0	CV	2. Date of Death Septemb	Day Year			
/Medic Examin		4a. Fecility Name (If not institution, give			4b. City, Town, o	Location of Deatl		4c. County of De			
	(*)	Sinai Hospital			Baltin If Under 1 Year	nore C	ity		/A		
Funeral Director		5. Social Security Number 6. Se 12-50-3992	x QM 2□F 7. Age (In yrs. la	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. B	rthplace (State or Foreign Country)		
		Usuel Residence of Decedent 10a, State 10b, County		Town or Lo	antion		00/14/15				
the Marylan 28a-f ehow	or	MD BALTIMO		NDALLS					10d. Inside City Limits		
or 28a-	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What C			
ath wit	raiD	9039 MEADOW HEIG			21133			U.S.A.			
be liled within 72 hours after death with the Maryland lat Hygiene. d other then "naturel", or items 23a or 28a-f ehow event, I're Modicel Examiner must be notified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	4	Vas Decedent of H f Yes, specify Cuba I □ Yes 2 🛣 No	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh Specify:			
n 72 hours *naturel;	Completed	15. Decedent's Edu (Specify only highest grad		16a. Deced	lent's Usual Occup	ation during most of wor	rkina 16	6b. Kind of Busines	s/industry		
within ane. then		Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of NOT use retired	1)		ACCOUNT	NC		
Illed I Hygie other	Be Co	17. Father's Name (First, Middle, Last)	7	ACCU	ONTANT	18. Mother's Nar	me (First, Middle, Ma	ACCOUNTI aiden Sumame)	NG		
Menta Menta arked atic ev	To B	ABRAHAM			ISTOCK	SARAH			BARON		
d 2 sh h and 7 is m treum		19a. Informant's Name/Relationship (T) ROSE WEISTOCK / N					ural Route Number, (
s 1 and f Heali		20a. Method of Disposition	20b. Pla	ace of Dispo	sition (Name of natory or other place	1	ROAD-RANDA	C. Location - City o			
Page ment o ant: If ury or		1 🕅 Burial 2 🗍 Cremation 3 🗍 f 4 🗍 Donation 5 🗎 Other (Specify)	temoval from State		IUNO CONG		09/2005 BA	ALTIMORE,	MD		
permit. Pages 1 and 2 should be lied within Department of Health and Mental Hygiene Important: If tlem 27 is marked other then eny injury or other treumatic event, the Magnes.		21. Signature of Juneral Service Licens	attle				L LEVINSON ROAD - PIH				
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ne cause on each line.			g, such as cardiad	or respiratory arres	t,	Approximate Interval Between Onset and Death		
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Lung (an ce	r				2 years		
Examiner	25	Convention list conditions	Pulmona		dema				8 days		
sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	erice ⊤f):							
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eath certifice attending ph	/Med	IF FEMALE:	23c. If yes, outcome of pregnan	101				L			
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at the	Phys	9 Unknown	9□ Unknown								
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute Chronic Renal Failure 1 Yes 2 No 3 Other part I.									
sician: The law certificate has b rector, page 2 sh	Completed						24a. Was an autopsy performe	id? death?			
sician certifi irector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Minpatient 2 □ E	ER/Outpatien	Oth		ath (Check only one)	a 77011 10			
g Phy ter this	-	27. Manner of Death		28b. Time of Injury	28c. Injun		lome 5 Residence 28d. Describe how		өспу)		
Attending Physician: or death. ector: After this certifica by the funeral director.	Certification:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 🗆	Yes 2□No					
lor At efter c Direc	ertifi	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)		eet, factory, office		28f. Location (Stree City or Town,	et and Number or F State)	Rural Route Number,		
To the Hospitel or Attending Physician: The within 24 hours effer death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifying Phy cone) 2 Medical Exami	sician: To the best of my know mer: On the basis of examinati and manner stated.	rledge, death on and/or in:	occurred at the ting restigation, in my of	ne, date and place pinion, death occu	, and due to the cau irred at the time, date	se(s) and manner a and place, and du	is stated. e to the cause(s)		
To th withir To th comp	Me	29b. Signature and title of codifier			29c. License			. Date signed (Mor			
		RES-00 September 8									
lo		30. Name and address of person who c Erika Oland	ompleted cause of death (Item	23a) (Type, 1	Print) ai Hosp	rital 104	Raltin	nore			
Sta		31. Date filed (Morth Cay, Year) 20	ompleted cause of death (Item 2. MD 32 Registrar's Signate 05	1º 60	ode		9.00177				
Registr	ar	OL1 1 2 20	The same of	17							

NANCY LEE WALDSACHS 05-06015 RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2005 29570 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day SEPTEMBER 3, 2005 8:49A /Medical Nancy Lee Waldsachs 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6401 LOCH RAVEN BLVD BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1□M 2₩F 64 Yrs. Director 213-38-9124 Feb 25, 1941 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow other than "natural", or items 23s or 28s-f ehovent, the Medical Examiner must be notified at MD 1√2 Yes 2 □ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6401 Locah Raven Blvd 21239 LISA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 21 No þ Specify: Specify: 3 ☐ Widowed 4 ₹ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk College (1-4or 5+) Elementary/Secondary (0-12) 0 12 secretary : If Item 27 le marked othe or other traumatic event, 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: if Item 27 is marked oth eny lightly or other traumatic event RRB. 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Sutton Sr Dorothy Horning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott Waldsachs/son 627 Melville Avenue Baltimore, MD 21215 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licens, e 22. Name and Address of Facility Prector State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 non Part1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) to Physician Circhosis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical d IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year 4☐Pregnant at time of death Day 5 Other (specify) ed by the a Ö 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed peed 24b. Were autopsy findings available prior to completion of cause of death?

1 √ 9s 2 □ No 24a. Was an page 2 : has autopsy performed? certificate Division of Vital 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \frak{M} Other (Specify) SCENEHospital: 1 Inpatient 2 ER/Outpatient 2 1 X Yes 2 ☐ No 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification; 28d. Describe how injury occurred 1 Natural 5 Pending Injury death. М 1 ☐ Yes 2 ☐ No 2 Accident investigation efter death Director: , 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel or within 24 hours e To the Funeral C 1 Certifying Physician: To the best of my knowledge ideath occurred at the time, data and place, and due to the causu(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. SEPTEMBER 4,2005 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 PENN STREET BALTIMORE, MARYLAND 21201 61.W 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 2 2005 Registrar

DHMH 17 Rev 1/2001

ISSAC YOUNG, JR. Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 120, 120, 17 State of Maryland / Department of Health and Mental Hygiene 200 05-06082 RJ 2005 Amend item #11 Per Inf. G84897109919999999 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 05 September 15, **Physician** У2005 7:15 р.м Isaac Young, Jr. /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6285 Oxon Hill Road Oxon Hill Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1⊠M 2□F Director 439-75-6779 31 Jan. 16,1974 Louisiana Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1ÆYes 2 □ No Arkansas Jefferson Pine Bluff 28a-f Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ir then "natural", or iteme 23a or the Medical Examiner must be 1308 Webb Street 71601 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. within 72 hours after 15 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: **≙** Specify: 3 ☐Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8th Contruction Road other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fil Iment of Health and Mental H tant: If Item 27 is marked otl Be Isaac Young, Sr. Vickie Blanch Boswell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other tree once. Gladys Reynolds (Sister) 2116 Hasting Crossing Texarkana, AR 71854 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) East Memorial Garden! 9-10-05 Texarkana, AR 21. Signal Je of Funeral Service 22. Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave. Catonsville, Maryland 21228 23a. Part1. Enter the disease, or primplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Gunshot Work /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed the burial-transit and Due to (or as a consequence of) Box 68760. ding physicien Physician/Medical as IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery atter 3 Ectopic pregnancy 2 | Fetal death ō in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month ed by the a Day Year 5 Other (specify) P.0. 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ should I Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1,25 Yes 2□ No hes autopsy performed? certificate of Vital 1 Ves 2 No Phyaicien: 25. Was case referred to medical examiner? director Be 26. Place of Death | Check only one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other 4 Nursing Home 5 Residence 6 Nother (Specify) At SCENE 1X Yes 2 □ No this : After this funeral of 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification Attending Division 1 Natural 5 Pending Injury death. Shor -05 19:02PM Decoased 1 Yes 2 No 2 Accident investigation the Funeral Director: npletely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospitel or Att within 24 hours after d To the Funeral Direct completely filled in by 28f. Location (Street and Number or Rural Route Number City or Town, State) (285 0) On Hill Rd 4 Homicide Parking Oxon Hill, MD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title 29c. License number 29d. Date signed (Month, Dey, Year) September 6, 2005 OCME

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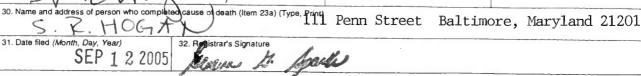
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State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) SEP 1 2 2005

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	Physic /Medi Examii	cal		Denise (If not institution, gi			City, Town, o		Augus		Year D5 5: nty of Death	40 A M			
	Funeral Director		5. Social Security P 216-22-9 Usual Residence of	Number 6. 138		Age (In yrs. last bi		Frede Joder 1 Year onths Days	If Under 24	Hrs. 8. Date of B Min. /Month, D July 12		9. Birthplace (S Country) Marylan			
	ne Maryland 8a-f ehow	ctor	10a. State Maryland	10b. County Frederic	:k	10c. City, Tow		า			10d. Inside City Limits 1 □ Yes 2 □ No				
	th with the	Funeral Director	10e. Street and Nu					f. Zip Code 21703			10g. Citizen of What Country? U.S.A.				
9600	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "naturel", or iteme 23a or 28a-f show other traumatic event, If a Medical Examinar must be notified at	d by Funer	11. Marita Status 1 Never Mari		Armed Ford 1 Tes 2 If Yes, Give Year or Dat	es:	1 🗆 Y	es 2 No	Specify:	n? (Specify Yes or N Puerto Rican, etc.)	o- 14. Race - American Indian, Black, White, etc. Specify: white Black				
215-(thin 72 he.	Completed by	(Spec	15. Decedent's E cify only highest gr andary (0-12)	ducation ade completed) College (1-4		. Decedent's (Give kind life. DO N	Usual Occupa of work done of OT use retired	ation during most o ()	f working	rking 16b. Kind of Business/Industry				
Maryland 21215-0036	should be filed wi and Mental Hygien marked other th umatic event, Ita	To Be Con	12 17. Father's Name Jose	(First, Middle, Last)	,	Never	Worked	18. Mother's	Name (First, Middle Dorsey		ever Work	ed		
Mary	id 2 shou th and M 27 ie mar traumat	-	19a. Informant's N	ame/Relationship	Type, Print)				and Number o	or Rural Route Numb					
Baltimore,	0 0		20a. Method of Dis 1 Burial 2		Removal from St	20b. Place o	f Disposition	(Name of		Date 30-2005	20c. Location	- City or Town, Sta Lck, Mary			
Balti	permit. Pag Department Importent: 1 any injury o		21. Signifigre of Fu	uneral Service Lice	nille	Eline	1621	Opossu	mtown	Stauffer Pike, Fre	derick,		d 21702		
	Physician /Medical Examiner	Iner	23a Part1. Enter t sock, or hea Immediate Cause disease or condition resulting in death) Sequentially list contains, to cause. Enter Under Cause, (Disease or	(Final on	a. Due to (or	as a consequence	In Fa	mode of dying		rdiac or respiratory a	Turest,	Interva	ximate al Between and Death		
(68760 ,	the death certificate be executed y the attending physicien and iched for use as the buriat-transit	Medicai Examiner	Cause (Disease or that initiated events resulting in death)	5	c	as a consequence	of):		APP	Jour	2				
P.O. Box	that the death certific ed by the attending p detached for use as	Physician/Me	23b. Was deceden in the past 12 1 Yes 2 9 Unknown	months?		n 2 Fetal death		oic pregnancy r (specify)				ate of delivery lonth Day	Year		
Records, P	w requires that been signed b should be deta	by	Part II. Other signif	icant conditions of	_	h but not resulting in	4	ng cause give	n in Part I.		obacco use cor Yes 2 No	ntribute to the cause			
Rec	The law ate has b page 2 st	Completed	<u>End</u> Sever	stage e Ity	renal pertens	diseas	se				an 24b. psy prmed? 2 No	Were autopsy find prior to completion death?	of cause of		
	Phyer this ral dir	n: To Be	25. Was case refer examiner? 1. Yes 2. 27. Manner of Deat	No	Hospital: 1 _ Inp	atient 2 ER/Ou	tpatient 3	DOA Cthe	r: 4 ☐ Nursir	Death (Check only ong Home 5 Resi			110,0000		
Division of	f or Attending I after death. Director: After I in by the funer	Certification:	1	5 Pending investigation 6 Could not be determined	28e. Place of	Injury - At home, fal	njury M	Work 1 □ Y	? es 2 □ No	E	Street and Num	ber or Rural Route	Number,		
۵	To the Hospitet or Atten within 24 hours after deal To the Funerel Director: completely filled in by the	edical Cer	29a. Certifier (Check only	1 Certifying Ph	ysician: To the be	est of my knowledge s of examination and	, death occu	red at the time	e, date and p	lace, and due to the		anner as stated.	Isa(s)		
	To the within 2 To the complet	Σ	29b. Signature and	title of certifier	Hil	stated.		29c. License	number			ed (Month, Day, Ye			
	Sta Registra	te	30. Name and address Francis 31. Date filed (Mont	G. Grill	0 , 604	Silver (Stem 23a) (Type, Print)	F 63	Freder	79	D 21	703			

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Mary	land / Do	epartment of H Certificate of I	lealth and Me Death	ental Hygie	ene 20 ()5	29573
	Dhusisi		1. Decedent's Name (First, Middle, Las		0 11			2. Date of Death Month			3. Time of Death
	Physici /Medio		Emily	۵	Bell			8	Day 29 Y	05	0125M
	Examir	er	4a. Facility Name (If not) institution, give	2 2 1 1 1		4b. City, Town, or	Location of Death		4c. County of		
	Firewall		Coastal Hospice 6. Security Number 6. Se		yrs. last birth	day) If Under 1 Year	17) If)Under 24 Hrs.	3. Date of Birth	WICOM		ce (State or Foreign
	Funeral Director			TM 200 E	6 Y	Months Days	Hours Min.	(Month, Day, Y 08/10/1		irgi	ce (State or Foreign
	pu >		Usual Residence of Decedent 10a. State 10b. County				J J	10/10/1) ±) V		
	fanyla shov	ō	,		c. City, Town					100	I. Inside City Limits 1 Yes 2 □ No
	28a-1	rect	MD Wicomic 10e. Street and Number	0	Salis	10f. Zip Code		100	. Citizen of Wha	at Country	
	h with	ai Di	312 Troopers Way			21804			USA		
	72 hours after death with the Maryland naturel', or items 23a or 28a-1 show disal Evantrat must be rodified at	Funeral Director	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S.	13. Was Decedent of Hi	ispanic Origin? (Spec in, Mexican, Puerto R	ify Yes or No-	14. Race -	American White, etc	
36	or its	y Fu	1 Never Married 2 Married	Armed Forcess 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:	ioan, etc.,	Specify:	white, etc	J.
Ö	hour Iturei	Completed by	3 Widowed 4 □ Divorced 15. Decedent's Ed		16а Г	Pecedent's Usual Occupa	ation	16		White	
75	nin 72 In "ne Medic	plet	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done of ife. DO NOT use retired	during most of working	7	b. Kind of busin	855/11005	suy
212	od with giene er the	Com	12	2		Nurse		1	Medical		
pu	be file tal Hy d oth event	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	First, Middle, Ma	iden Sumame)		
Z	d Men d Men marke marke	P	Bertie R. Ellis 19a. Informant's Name/Relationship (7	ino Crinti	105.1		Rhona May		- T	. = 0	
Maryland 21215-0036	nd 2 s lth an 27 is r traur		Rosalie Hurley/Da	**		Mailing Address (Street a				.te, Zip Co	ode)
	s 1 ar if Hea item other		20a. Method of Disposition	2	Ob. Place of D	Disposition (Name of crematory or other place	Da		c. Location - Cit	y or Town	n, State
E C	Page nent o		Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify		-	Baptist Cem		2005 Po	comoke	City	, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examinations be notified at once.	1	1. Signature of Funeral Service Liden:	:86		22. Name and Addres Hinman Fun	s of Facility	2005			•
_	<u>v</u> ∪ = 9	7	3a. Part1. Enter the disease, or comp	MUMAMO	0295	11673 Some	rset Ave	Princes	s Anne,	MD	21853
			shock, or heart failure. List only of	ne cause on each line.	death. Do no			respiratory arrest	ι,	In O	pproximate iterval Between inset and Death
	Pnysician /Medical	U	disease or condition resulting in death)	a. Due to (or as a co	nnonuonan of	Cerynor	non			10	months
	Examiner				insequence of						
	P =	ner	Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury	Due to (or as a co	nsequence of	i:					
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a co							
60,	icate be executed physician and s the burial-transit	ai E		D09 to (01 as a co	insequence or,						
68760,		edicai		d							
Вох	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	M/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		205-4			23d. Date of	f delivery	
	that the death cer ed by the attendin detached for use	Physician/M	in the past 12 pronths? 1 Yes 2 No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	····		Month	Da	ay Year
P.O.	nat the d by tl letach	Phy	9 ☐ Unknowh Part II. Other significant conditions co		et annulting in t		a in Book I	One Diduction		A - A - M	
ds,	signed be det	d by	Tarrii. Other significant containons co	minutaling to death but no	or resulting in t	ne underlying cause give	en in Part I.	1 Yes	cco use contribu		ly 4 Unknown
Vital Records,	w requir been si should	Completed						24a. Was an	-		findings available
Re	he lav e has age 2	omo						autopsy performe	prior	r to completh?	letion of cause of
ta		a	25. Was case referred to medical				26. Place of Death		\$No 1□	Yes 21	A No
of <	Physical this ceral direct	To B	examiner?	Hospital: 1 Impatient	2 ER/Outp	atient 3 DOA Othe	er: 4 🗌 Nursing Home		e 6 Other (Specify)	
o uc	ing P	ion:	27 Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Tin	ne of 28c. injury	at 28	d. Describe how			
Division	death ctor: ,	licat	2 Accident investigation 3 Suicide 6 Could not be	28e Place of Injury	At home, farm	M 1 1	res 2 □ No	f. Location (Stree	at and Number	r Dural D	outo Alumbos
<u>S</u>	after I Dire	Certification:	4 Homicide determined	building, etc. (S	pecify)	, ottobi, laddiy, dillog		City or Town, S	State)	7 7 101 01 1 1	oute reamber,
	ospite hours unere ly fille		29a. Certifier Certifying Phy	sician: To the best of m	y knowledge, o	death occurred at the tim	e, date and place, an	d due to the caus	se(s) and manne	r as state	od.
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director.	Medical	01101	iner: On the basis of exa and manner stated.	mination and/						
	To To con	2	29b. Signature and title of certifier	100	M	29c. License		29d.	Date signed (M	lonth, Day	y, Year)
,			30. Name and address of person who c	ompleted cause of death	(Item 23a) (T	and Drint)	16278		01.	-0-	۵
		Ì	DAUD COURLY, WY	(1)		PO BOX	(1733	Scolish	MA	21	1802
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Sperke		(7		
	Registr	ar	SEP - 2	2005	n &	Soule					

Jill Ann Barnett 05-05747 NJM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle Last Month Day Year Jill **Physician** Ann Barnett 25 2005 1720 August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner New Market Under 1 Year | If Under 24 Hrs. Frederick Route 75 & Old New Market Road 8. Date of Birth (Month, Day, Year) July 20,1968 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 💆 F Months 212-78-2116 37 Maryland Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State 28a-f show treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No MD Frederick Director Union Bridge 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? ō 12539 Molasses Rd. itете 23a 21791 permit. Pages 1 and 2 should be filed within 72 hours atter death v Depertment of Health and Menta! Hygiene importent: If item 27 is marked other then "natural", or iteme 23a enty injury or other treumatic event, the Medical Exemples pages. U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: White 3 ☐ Widowed 4 NDivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) waitress/homemaker restaurant/own home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles W. Grabill Mary Fisher ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charles W. Grabill - father 12539 Molasses Rd., Union Bridge, MD 21791 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Johnsville Meth. Cem. 8/30/2005 Johnsville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service License atharine 11802 Liberty Rd., Libertytown, MD 21762 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 14 juries Multiple **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physicien end s the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy etter for u Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 **™**Unknown should be det Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records. 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t irector, page 2 s death? 1 Yes Yes 2 No 2 No director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Scene 1 XYes 2 □ No ၉ this After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: is volved in motor vehicle Driver 15 Vollison Injury within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune $\frac{1}{\sqrt{1-C}}$ 1 Natural 5 Pending 8/25/05 2 Accident 3 Suicide 17:16 investigation 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 | Homicide street Route 75 at old New Market Red, Fridge Medical 29a. Certifie t 🗆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie WSL August, 26, 2005 OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 CABILLEAH 111 Penn Street Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

RJ	J J J I			State of Mar						
		•	For State Registrar		Cei	rtificate of	Death		g. No. 200	
	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Oate of Death Month	er 1, 2005	3. Time of Death 11:00 pM
	/Medic	al	Frank Ran		kenship	4h City Town	or Location of Death	septembe	4c. County of Deat	
	Examin	er	411 Robinhood Road				de Grace			1 County
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birtl	nplace (State or Foreign untry)
	Director		212-96-6733]M 2□F	24 Yrs.			Oct. 24	, 1980 Mar	
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary a-f eh	tor	MD Cecil		Perryv	rille				1 ∑Yes 2 □ No
	ith the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	s 23s		3-C Owen's Landin	g Court 12. Was Decedent Ev	er in U.S. 12	2190		ecify Yes or No-	U.S.A.	ncan Indian
40	fter de	Funerai	11. Marital Status 1 ☑ Never Married 2 ☐ Married	Armed Forces? 1 □ Yes 2127 No			Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, White	
036	filed within 72 hours after death with the Maryland Hygiene. sther then "naturel", or Items 23a or 28a-f ehow ent, the Madical Examinat must be notified at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2√2 No	Specify:		Specify: W	nite
5-0	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	cation e <i>completed)</i>	16a. Dece	dent's Usual Occup kind of work done	pation during most of work id)	ing	16b. Kind of Business/	Industry
121	within ene. then	dwc	Elementary/Secondary (0-12)	College (1-4or 5+)	rician	(d)		Electric	
<u>5</u>	illed Hygi other	Be C	17. Father's Name (First, Middle, Last)	V			18. Mother's Nam	e (First, Middle, M		
/lar	wid be Menta rrked stic ev	To B	Norman R. Blanken	ship				. Wagone		
Baltimore, Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or Items 23s or 28s-f show any injury or other treumatic event, the Madical Examinar must be notified at ODEs.	0 1	19a. Informant's Name/Relationship (Ty Norman R. Blanken				and Number or Rur Landing C		City or Town, State, 2	
e e	1 and Health em 27 ther t		20a. Method of Disposition	Simp (rau	20h. Place of Dispe	osition /Name of		Date 2	20c. Location - City or	
υor	eges ant of it: If It	İ	1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		Bel Air M	matory or other pla lemorial	Gardens ^{7/}	05	al Air, Ma	ryland
altir	mit. F pertme sortan / Injur		21. Signature of Funeral Service License		3	2. Name and Addre	ess of Facility			
ä	90 E 90		1	OUV_			argo Fune Maryland			
			23a. Part1. Enter the disease, or complishock, or heert failure. List only or	ications that caused t ne cause on each line	he death. Oo not en	ter the mode of dy	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	Multer	le i	njure	J		
	Examiner	•		Due to (or as a	consequence of)!					
	/n ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
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	uficate g phy: as the	edic		u.			1974.9			
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O.	ne dea the at hed fo	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at ti 9□ Unknown	ime of death 5	Other (specify) _				
ď.	wrequires that the death certificate been signed by the attending phy should be detached for use as the	y Ph	Part II. Other significant conditions con	ntributing to death but	t not resulting in the	underlying cause g	ven in Part I.	23e. Did tob	acco use contribute to	the cause of death?
rds	quires on sign	ed by						1 □ Ye	is 200 No 3 □ Pr	obabiy 4 Unknown
600	a 8 C	Completed						24a. Was ar autops	v prior to	topsy findings available completion of cause of
<u> </u>	: The cete h							yes 2	!□ No 1X Yes	2 No
Z: Z:	siclar certif	o Be	25. Was case referred to medical examiner? 1 ★ Yes 2 → No	Hospital:	t 2 ☐ ER/Outpatie	int 3 DOA O		th Check only on	e) ince 6 ∰Other (Spe	at scene
o to	g Phy er this ieral d	٦.	27. Manner of Death	28a. Date of Injury	/ 28b. Time (28d. Describe ho		
ij	endin sath. or: Aft he fur	atio	1 Natural 5 Pending investigation	911105	- 225		Yes 2 No	majo reyal		citar verilla
Division of Vital Records, P.O.	lor Att efter d Direct	Certification:	*3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injui building, etc.	ry - At home, farm, si . (Specify)			City or Town		A A
П	To the Hospital or Attending Physician: The I within 24 hours efter death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page				f my knowledge, dea	th occurred at the		and due to the ca	ause(s) and manner as	
	To the Hospital within 24 hours of To the Funeral completely filled	Medicai	(Check only 2X) Medical Exami	iner: On the basis of and manner stat		nvestigation, in my	opinion, death occu	12	and place, and due	ace MM
	To the within 2 To the complet	Σ	29b. Signature and title of certifier			29c. Licer OC	ise number ME		9d. Date signed <i>(Mont</i> eptember 2	• • • • • • • • • • • • • • • • • • • •
	j		(& cake		oth (Itom 22c) (To-	Print\				1414.
	6		30. Name and Todress of person who o	ompleted cause of de	au (nom zoa) (1996	111' Penn	Street B	altimore	, Maryland	21201
		ate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	all I				
7	Regist	гаг	CED 0 9 200	5 Malues	J.F. JADO					

	1	For Stata Registrar			State of I	Maryla	and /		artmen rtificate					Reg. No	20	05	29576
Physician /Medical		MARGAR a. Facility Name (i	ET MASO	N B		ar)			4h City	Town or	Location	of Death	2. Date of D Month Augus	1 2	8 20 County	Year 005	3. Time of Death /0:50 AM
Examiner Funeral		11.	dun 1	11.	bR.	Age (In y	rs. last b	oirthday)	PR.	1) CL	SS If Under	24 Hrs.	8. Date of B	Sirth	Som	erse	2.f place (State or Foreign ntry)
Director	-	225-76-5 Isual Residence o		1 🗆	M 2 X F		90	Yrs.	Months	Days	Hours	Min.	6-29-	Day, Year -1915	5	Vir	ginia
Maryland a-f show lifed at	1	0a. State	10b. County Somer	set				wn or Lo	cation Anne	2							10d. Inside City Limits 1 XYes 2 □ No
vith the	1	0e. Street and Nu							10f. Zip					10g. C	itizen of W	/hat Cou	ntry?
yland 21215-0036 ould be filled within 72 hours after death with the Marylan Mental Hygiene. arked other than "netural", or Items 23a or 28a-f show atte event, the Medical Experiment and the notified at To Be Completed by Funeral Director	1	11976 E 1. Marital Status 1 Never Marr 3 Widowed	ried 2 Marri	1	ETACE 2. Was Decede Armed Force 1 ☐ Yes 2: If Yes, Give Year or Date	es? X No	U.S.	1			ispanic Or in, Mexican Specify:		ecify Yes or N Rican, etc.)			k, White,	can Indian, etc. Vhite
21215-0036 ed within 72 hours af yogene. ner than "netural", or it, the Medical Exert Completed by F		(Spec	15. Decedent cify only highes ondary (0-12)	s Educ grade	ation completed) College (1-4	or 5+)	16	a. Dece (Give life.	dent's Usua kind of wo OO NOT us	al Occup rk done d se retired	ation during mos d)	t of work	ing	16b. I	Kind of Bu	siness/In	dustry
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Maryland 212' d 2 should be filed within th and Mental Hygiene. 27 is marked other than traumatic event, file M	1	James W											elson	е, маше	n Surnam	в)	
Mary 2 sho 1 and 1 s ma raum		19a. Informant's N		,.					•				al Route Num				
	2		position Cremation	3 □Re		- 1	o. Place	of Dispo	osition (Nar. matory or o	ne of ther plac	(e)		Date	20c. L	ocation -	City or T	MD 21851 own, State
Baltimore, permit. Pages 1 ar Department of Hea Importent: If Item eny Injury or othe once.	1	` 4 ☐ Donation 21. Signature of F			7 -		Бел	1 2	2. Name ar	d Addre	ss of Facili	ty			le Ha		23350 ore, Va.
ate be executed ate be executed whistian and pour all transit lead Examiner		Immediate Cause disease or condition resulting in death) Sequentially list or cause. Enter Undeathology ause. Enter Undeathology resulting in death)	onditions, modula erlying erlying rijury s	b.	Due to (or	as a cons	sequenc	e of):									Onset and Death
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dS, P.O. I uires that the de signed by the a ld be detached f d by Physic	1	Part II. Other sign	ificant conditio	ns con	tributing to dear	th but not	resulting	g in the u	ınderlying o	ause giv	en in Part	l.			/	ibute to t 3 ☐ Proi	he cause of death? bably 4 □Unknown
Division of Vital Records, or attending Physicien: The law requires t after death. Director: After this certificate hes been signe in by the funeral director, page 2 should be ertification; To Be Completed by	-												24a. Wa aut per 1 🗆 Yes	as an lopsy rformed? 2 N	24b. V	eath?	opsy findings available impletion of cause of
Vital F icien: Th certificate rector, pag	1	25. Was case refe examiner?		Н	ospital:					Oth	or /		h (Check onl)				
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Division of tell or Attending P is after death. el Director: After tied in by the funera Certification;		3 Suicide 4 Homicide	6 Could r	not be	28e. Place of building	f Injury - A J, etc. (Sp	At home, ecify)	farm, st	reet, factor	, office				(Street a own, Sta		er or Run	al Route Number,
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To the within 2 To the complet		29b. Signature an	d title of certified	•					290	Dosa :	e number			29d. D	ate signed	39/1	Day, Year)
3		30. Name and add	dress of person		mpleted cause	of death (Item 23	a) (Type	Print) S - Di v	15/01	~ 57	30	2 (8134 14	24 1	ב מר	2/50	4
State Registrar		31. Date filed (Mo			32. Rec	gistrar's Si	ignature		a second					1			<i></i>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 29577 For State Amended 4a perMD FCHD, KS Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 25 2005 AUGUST 7.37 a **JAMES** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number)
812 Blakely Court, Apt. 2
Frederick Memorial Hospi 4b. City. Town, or Location of Death Examiner Frederick Frederick If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Dec. 3, 1956 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1⋤M 2□F 48 216-72-1512 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County item 27 is marked other than "natural", or items 23a or 28a-1 show other treumatic event, the Medical Examinar must be notified at 1 Yes 2 No Funeral Director Frederick Frederick Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 812 Blakely Court, Apartment 266 21702 United States 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "na any injury or other treumatic event, the Medic 2008. Elementary/Secondary (0-12) College (1-4or 5+) Aircraft Feuler / Instructor Aviation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Virginia Elizabeth Wilt Austin James Burdette 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 812 Blakely Ct., Apt. 266 Frederick, MD 21702 Virginia Burdette / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) August 27, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2005 Baltimore, Maryland * 4 ☐Donation 5 ☐ Other (Specify) Greenmount Crematory 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 21. Signature of Funeral Se 23a. Part. Enter the disease, or oppositions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or rear failure. List one cause on each line. atheroscleratic condiovascular disease Immediate Cause (Final several years **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical the for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2.2 No 4☐Pregnant at time of death 5 Other (specify) the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by weilits 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? the funeral director, page 2: certificate has 1 Yes or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury 1 Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 - Homicide racertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier NA 24/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick Heitzier MD Solarex 010 Dale s Signature 31. Date filed (Month, Day, Year) 32. Regist State AUG 2 9 2005 > Registrar

		. For	State of Ma			lealth and Me	•	ne	- 00
		1 - Stete Registrar		Ce	ertificate of	Death	Reg.	No. 200	29578
Physi /Med		Decedent's Name (First, Middle, L Frances Lynn Co	ast) otton			1	Date of Death Month Deptember	Day Year	3. Time of Death S 12.07 AM
Exam		4a. Facility Name (If not institution, ga	ive street and number)		4b. City, Town, o	r Location of Death		4c. County of Dea	th
		Western Maryland			Hagers			Washingt	
Funera			Sex 7. Ag	e (In yrs. last birthda) 57 Yrs.	Months Days	Hours Min.	Date of Birth (Month, Day, Ye Ct. 5 19	9. Bir 047 DC,	hplace (State or Foreign buntry)
Directo	r	219-48-0595 Usual Residence of Decedent		57 Yrs.		0	ct. 5 19	747 DC,	Washington
land		10a. State 10b. County		10c. City, Town or I	_ocation				10d. Inside City Limits
Many Ff sh	to	Maryland Washing	2ton	Hagersto	v n				Yes 2 No
h the	lrec	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	ountry?
th wit	a	1037 Glenwood Av	7e		2174		US		
15-UU36 n 72 hours after death with the Maryland neturel; or items 23e or 28e-f show edical Evantmer must be notified at	by Funeral Directo	11. Maritat Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 1 If Yes, Give Year or Dates:	Ever in U.S. 13	. Was Decedent of hill Yes, specify Cuba	dispanic Origin? (Specif an, Mexican, Puerto Ric Specify:	y Yes or No- can, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
5-0036 72 hours af neturel; or dical Example.	ted	15. Decedent's	Education	16a. Dec	edent's Usual Occup	pation	16b	o. Kind of Business	/Industry
within 7 lene.	Completed	(Specify only highest g Etementary/Secondary (0-12)	College (1-4or 5	i+)		during most of working d)	1		
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	2	Harry Comb Atkin		10h Ma	ling Addross (Strant	and Number or Rural R			Zin Code)
Mary d 2 shou th and M 7 Is mar treumat		19a. Informant's Name/Relationship							Lip Code)
ther		Joe Dunsworth/So	<u>n</u>		C. FLAIIK. consition (Name of ematory or other place	Lin St Hage		Location - City or	Town, State
Pages Pages nent of nnt: If it		1 X Burial 2 ☐ Cremation 3 1 Donation 5 ☐ Other (Spec		1	ematory or other plac en Cemetei	ry Sept 8	2005 Ha	agerstown	MD
	ei .	21. Signature of Funeral Septice Lice			22. Name and Addre			Funeral C	
Departiment import	a	1.1	Lun	_	1601 Penns	sylvania Av	e Hagers	stown MD2	
		23a. Part1. Enter the disease, or co shock, or heart failure. List onl	mplications that caused by one cause on each li	the death. Do not e	nter the mode of dyir	ng, such as cardiac or r	espiratory arrest,		Approximate Interval Between Onset and Death
Physicial /Medica		tmmediate Cause (Final disease or condition resulting in death)	a acu	a consequence of):	cardia	l Infanc Ossease	um		30 minules
Examine			Due to (or as	a consequence oi).	n/au	Disease			Years
	ē l	S yential y list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of):					
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/ 6U, B be executed sician and burial-transit		resulting in death) Last		a consequence of):	4		1 4		W 44 4
. BOX 68/6U, death certificate be executed e attending physician and of for use as the burial-transi	lical	•	o Chro	me olls	ruce	lung d	vicase		Years,
BOX 68 feath certificate attending phys	Physician/Medi	IF FEMALE:	23c. If yes, outcome	of programmy				2015	
BOX auth cer attendir for use	ian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	☐Ectopic pregnancy	У		23d. Date of de Month	Day Year
the da	ysic	1 □ Yes 2 DNo 9 □ Unknown	9□ Unknown	timo or dodin					
T ta ta	by Ph	Part II. Other significant conditions			underlying cause giv	ven in Part I.	23e. Did tobac	co use contribute to	the cause of death?
rdS quires	g p	seieus	e Disor	der			1 ☐ Yes	2 □ No 3 □ P	obably 4 Unknown
s bee	olete	morbio	d obesil	r H			24a. Was an autopsy	24b. Were at	utopsy findings available completion of cause of
The law	Completed	Ronal	insulli	ulucy			performed	? death?	2 □ No
I VITAI KECONAS, ysiclen: The law requires t is certificate has been signe director, page 2 should be	Be	25. Was case referred to medical examiner?	7.75	0		26. Place of Death (0	Check only one)		
OT V Physic rthis ce	2	1 ☐ Yes 2 No		ent 2 ER/Outpati	ent 3 DOA	4 Nursing Home			cify)
On O	ü	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	ry 28b. Time y Year) Injury	Wo		d. Describe how i	njury occurred	
VISION OF VITA Attending Physiclen: sr death. ector: After this certifice by the funeral director.	catl	2 Accident investigate 3 Suicide 6 Could not	be an Bloom of Ini	ury - At home, farm,		Yes 2 □ No	Location (Stree	t and Number or R	ural Route Number.
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DIVISIO To the Hospitei or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the ti	ledical C		Physicien: To the best eminer: On the basis o and manner st	f examination and/or					
o the o the	Med	29b. Signature and title of certifier)		29c. Licens		29d.	Date signed (Mont	h, Day, Year)
- s = 0		1	76	6	D	44996	Se	ptember	, 1, 2005
4		30. Name and address of person wh	o completed cause of c	leath (Item 23a) (Typ		Pennsylva	nia Aven		
		Latar Mal	IK MD		Hage	erstown, MD	21742		
Regis	State	31. Date filed (Month, Day, Year)	32. Regitt	ar's Signature	Lists 5				

DHMH 17 Rev 1/2001

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melio

ORIGINAL

Please Type or Print in Black Indelible Inks Ensure All Copies Are Legible.
Amend j.tem#31, per DVR, Department of Health and Mental Hygione

		Ameno 1 - State Registrar	State of N	Maryland /	-	artment of H				2005	29580
Physici	an	1. Decedent's Name (First, Middle, Las	-	ς Δ				2. Date of De Month	ath Day	Year	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give	street and numbe	r)		4b. City, Town, or			4c. C	ounty of Death	
Funeral Director		Social Security Number 6. S		Age (In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Mi		th y, Year) _ 194		ace (State or Foreign try) ngton D. C.
<u>0</u>		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	vn or Lo	eation					Od. Inside City Limits
h the Ma or 28a-f s	Director	Maryland Montgo	mery	Damasc	us	10f. Zip Code			10g. Citize	on of What Count	1 ☐ Yes 2 ☒ No try?
ite, Intallylating ZIZIS-DUSO s 1 and 2 should be filed within 72 hours after deeth with the Maryland if Health and Mental Hygiene. item 27 is marked other then "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Examination at the Invitinal at	by Funeral D	25900 Ridge Manor 11. Marital Status 1 Never Married 2 Married	12. Was Deceder Armed Forces 1 XYes 2 If Yes, Give	s?]No		20 Was Decedent of Hir If Yes, specify Cubar	9872 spanic Origin? n, Mexican, Pue Specify:	Specify Yes or No irto Rican, etc.)	- 14	ed State Race - America Black, White, e	an Indian, atc.
vithin 72 hours ne. hen "natural"	Completed b	3 ☐ Widowed 4 ☒ Divorced 15. Decedent's Ed (Specify only highest grade) Elementary/Secondary (0-12)	ucation de completed) College (1-40		a. Dece	dent's Usual Occupa kind of work done d DO NOT use retired)	uring most of w	orking		f of Business/Ind	
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permit. Pages Department of Importent: If it any injury or o		21. Signature of Fureral Service Licen		w	()	Name and Addres	s of Facility	h P. A. I	unera	1 Home	
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/Medical Examiner		resulting in death)	a	as a consequence							
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To the Hospital or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medical (of examination a		n occurred at the tim vestigation, in my op	inion, death oc	curred at the time,	date and p	lace, and due to	the cause(s)
To T Com	Σ	29b. Signature and title of certifier	E m	D		29c. License	number 6298-			signed (Month, E	
BXIV		30. Name and address of person who		f death (Item 23a)	(Туре.	Print) edical Cen	ter Driv	e Pocku	.lle, M	anland	20850
Sta Registr		31. Date filed (Months)	of range	Signature SUUC	Û 8	Ont AUG	3 0 200	5 Gener	n de	A Apan	20850

			1 - For State Registrar	of Marylan		artment rtificate			and M		giene 2	005	295	8
	Physici	an	Decedent's Name (First, Middle, Last) Marcelline	Cummings	5	-				2. Date of Dea	ath aber 42	ďð t	3. Time of Death	
	/Medio	al	4a. Facility Name (If not institution, give street and			4b. City,	Town, or	Location of	of Death	Depear	4c. County		3.00 1	
	Examili	iei	Moran Manor Nursing			We:	ster	nport			Alle	gany		
	Funeral Director		5. Social Security Number 220-10-7282 6. Sex 1 □ M 2 🔀	7. Age (In yrs. i 86	last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birt (Month, Day March 2	1 1919	9. Birthr Cour Mar	place (State or Fore htry) yland	əign
Ī	land		Usual Residence of Decedent 10a. State 10b. County		y, Town or Lo							1	0d. Inside City Lim	nits
	a-f sh	ctor	MD. Allegany	Wes	sternp	ort							¥2¥Yes 2□	No
	th with the 23e or 28	Funeral Director	10e. Street and Number 421 Hammond St.			10f. Zip 2	^{Code} 1562				10g. Citizen of V United			
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or itema 23e or 28a-f show my injury or other treumatic event, it a Modical Exactinal result to modified at ance.	ρ	1. Armed 1 Yes	Decedent Ever in U. I Forces? es 2 22 N o Give or Date <i>s</i> :	-1	Was Deced If Yes, spec 1 ☐ Yes 2		spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto F	city Yes or No- Rican, etc.)	14. Race Blac Specify	k, White,	ean Indian, etc. ite	
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Maryland	and 2 shoule alth and Min 27 is marisar treumati		19a. Informant's Name/Relationship (Type, Print) Phyllis Deniker/ frier	nd		•					or, City or Town,			
Baltimore,	Pages 1 and 2 nent of Health int: If Itam 27 iry or othar tre		20a. Method of Disposition ★★Burial 2 □ Cremation 3 □ Removal fr 4 □ Donation 5 □ Other (Specify)	om State	lace of Dispo emetery, crer • Pete	natory or of	ner place		09/0 2005	ate 8/	20c. Location - Western		wn, State Maryland	d
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Division	s after d	Certification:	determined 288. P	ace of Injury - At ho uilding, etc. (Specify	ome, farm, str	eet, factory,	, office		2	8f. Location (S City or Tow	treet and Numbern, State)	er or Rura	i Route Number,	
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١	To t To t	Σ	29b. Signature and title of certifier	Jana-		29c.	License	number	12	1	29d. Date signed	(Month,	Day, Year)	
,			30. Name and address of person who completed of	ause of death (Item	23a) (Type	Print)	11	>40	2		ZEPlem	her	0,000	5
		4		Main St		ternp	ort,	Mary	land	21562	2 /			
	Sta Registi		31. Date filed (Month, Day, Year) 3. SEP = 6 2005	2. Registrar's Signa	/	WE								

			1 - For State Registrar	State of M	larylan		artment <i>tificate</i>			ınd M		iene,	200	5 29	582
	Physici	an	1. Decedent's Name (First, Middle, L	ast)							2. Date of Deal		Yea	3. Time o	f Death
	Physici /Medio		Bryan Le			Case					August	22	2005	5:46	ам
	Examin	er	4a. Facility Name (If not institution, ga)		4b. City, To					4c. C	ounty of De	eath	
	<u></u>		111 Evergreen		//	1			Parl					runde1	
	Funeral Director		5. Social Security Number 6. 216–78–5090	Sex 7.A	ge (<i>in yr</i> s. i	last birthday) Yrs.	If Under 1 Months	Days	If Under 2 Hours		8. Date of Birth (Month, Day, July 23	Year)	9. 5	Birthplace (State of Country)	or Foreign
			Usual Residence of Decedent		40						July 23	,195	9	Texas	
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside C	ity Limits
	Mar a-f st	ţċ	MD Anne A	rundel	Se	everna	Park							1 ☐ Yes	2 No
	h the	Director	10e. Street and Number				10f. Zip C	Code			1	0g. Citize	on of What	Country?	
	th wil		111 Evergreen	Road				21	1146				USA		
	ams rdea	Funeral	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.	.S. 13.	Vas Decede	nt of His	panic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	14	Race - Ar Black, Wi	nerican Indian,	
36	or it	y Fu	1 Never Married 2 Married	1 XYes 2	No		ı □ Yes X	777	Specify:	, , , , , , , , , , , , , , , , , , , ,	110411, 010.)		pecify:	White	
8	ural	d by	3 Widowed 4 Divorced	Year or Dates	1981	-01									
15	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28a-f show fra Modical Examires must be multired at	Completed	15. Decedent's E (Specify only highest g	rade completed)		(Give	lent's Usual kind of work DO NOT use	done du	tion <i>tring</i> most	of workir	ng	16b. Kind	of Busines	ss/Industry	
72	with ene.	Ĕ	Elementary/Secondary (0-12)	College (1-4or	5+)		er Ser		n t			TT C	۸iۍ	Force	
D	Hyg Hyg other ant,	Be C	17. Father's Name (First, Middle, Las	<u>-</u>		11400	JI JUI			r's Name	(First, Middle, M			rorce	
lan	lid be lental rked	To B	William Noel Ca	se					H. R	osa1	ie Broda	2			
Maryland 21215-0036	shou and N		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	g Address (S				Route Number		Town, State	, Zip Code)	
	and 2 paith 3 27 i		Dawn M. Case (W	ife)			_		Road	, Se	verna P	ark,	MD 2	1146	
ore	of He fitan roth		20a. Method of Disposition 1 □ Burial 2 X Cremation 3	□ Bemoval from State		lace of Dispo emetery, cren	sition (Name natory or othe	of er place,	, [D	ate :	20c. Loca	tion - City o	or Town, State	
Ĕ	Pag ment ant: i		`4 □ Donation 5 □ Other (Spec			tro Cre	mator	У		8 – 23	-2005	Balt:	imore	, MD	
Baltimore,	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic evant, firs Madical Examination at De natified at once.		21. Signature of Furteral Service Lice	enseer		22	Name and	Address	of Facility	al F	lome, P.	Α			
_	6 # 5.0 P		· Las	ann			12 K10	igel	y Ave	enue,	, Annapo	lis,	MD 2	1401	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that cause y one cause o v- ach	d the death	n. Do not ent	er the mode	of dying,	such as o	cardiac o	r respiratory arre	est,		Approximat Interval Bet	tween
	Pnysician		Immediate Cause (Final disease or condition	Ch	ulo	nge	v Car	10	in	0	me			Onset and	Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consequ	uence 🕥									
B	_xanimici	e	Sequentially list conditions,	b											
	ted 1sit	nine	if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury	Due to (or a	a consequ	dence or):									
	al-trai	Examin	that initiated events resulting in death) Last	c Due to (or as	a consequ	uence of):				_					
8760,	cate be executed physician and the burial-transit	dicai E													
687		edic		0.											
Вох	death certifi e attending id for use as	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregna							230	d. Date of d	elivery	
œ.	death e atte ed for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic preg Other (spec					100	Month	Day '	Year
P.O.	that the death certified by the attending detached for use as	Physician/Me	9 Unknown	9□ Unknown											
Ś	The law requires that the te has been signed by thi sage 2 should be detache	by F	Part II. Other significent conditions	contributing to death	out not resu	ulting in the un	derlying cau	ise given	in Part I.		23e. Did tob	acco use	contribute	to the cause of d	eath?
ord	w requir been si should										1 ☐ Ye	s 2	No 3□F	Probably 4 □l	Jnknown
ecc	e law r has be	ple									24a. Was ar autopsy		24b. Were a	autopsy findings	available
Vital Record		Completed									perform	ed?	death? 1 ☐ Ye		
/ita	ilcian: Th	Be	25. Was case referred to medical examiner?	/ Managhali						of Death	Check onl one	9	P	ANCHI	-5
of	Physician: this certific	7	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital:		ER/Outpatien	-	Other	4 🗀 (Nul)	1000000	e 5 Reside		ther (Sp	ecify) + h	ME
UQ.	ding After funer	ion	t Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	y Year)	28b. Time of Injury	28C	Work?	ut es 2 □ N		8d. Describe ho	w injury c	ccurred		
Division	Attanding r death. ector: After by the fune	lical	2 Accident investigation 3 Suicide 6 Could not I	De Diago of In	iury - At ho	me farm stre			35 Z 🗆 IV	-	Rf Location /Str	eet and A	lumberori	Rural Route Num	bor
<u>S</u>	after after Dire	Certification:	4 Homicide determined	building, e	tc. (Specify	<i>'</i>)	ot, ractory, c	Jilloa		-	City or Town		tunibor or r	18/2/ / 10810 / 18/11	Der,
	spits nours neral		29a. Certifier 1 Certifying P	hysician: To the best	of my know	wledge, death	occurred at	the time.	, date and	place, a	nd due to the ca	use(s) an	d manner a	as stated.	
	To the Hospital or Attantwithin 24 hours after deation to the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Exa	miner: On the basis of and manner s	or examinati	ion and/or inv	estigation, in	my opir	nion, death	occurre	d at the time, da	te and pl	ace, and du	e to the cause(s)
	To t To t	Ž	29b. Signature and title of certifier	$\sim D$	٨		29c. L	icense r	number		29	d. Date s	igned (Mor	nth, Day, Year)	
}			may	He	A10	16		(i	211	438		/ tu	92	2 20	100
			30. Name and address of person who	11/2	death (Item	23а) (Туре, І	Print)	1,~	(m)	15	L		A	APE. I IAA	10
			MIC (TYTEL _	1. Caren		w 4	47 1	ノじり	EN	SC	416 H	VAY	1.00/1	POLIJ M	1-1150
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 4	2005 32. Project	rar's Signat	B A	and a	,				, ,		V 1 T V 1	

			1- For State of Maryland / Department of Health and Mental Hygiene Certificate of Death Certificate of Death Reg. No. 2005	583
	Physici	20	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year	f Death
	/Medic		Virginia Lee Cantville Aug. 23, 2005 2149	М
	Examir	er		
			3986 Ocean Gateway Trappe Talbot	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Under 1 Year 1 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country) 1 Months Days Hours Min. 1 If 1007 1 If 10	or Foreign
	Director		Usual Residence of Decedent 78 Yrs. March 15, 1927 Maryland	
	/land		10a. State 10b. County 10c. City, Town or Location 10d. Inside 0	City Limits
7	Man a-f sh	호	Maryland Talbot Trappe	2 🗆 No
	or 28	irec	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
2	23a c	Funeral Directo	3986 Ocean Gateway 21673 USA	
2	eep superior	iner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.	
98	or it	Y.	1 Never Married 2 Married 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes, Give 1 Yes, Specify: Specify: Specify:	
5-0036	72 hours after deeth with the Maryland natural', or items 23a or 28e-f show dieal Exandrer must be profilled at	d by	Year or Dates:	
15-	"nat	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry	
2121	within lene. than "	mc	Elementary/Secondary (0-12) College (1-4or 5+) Dietary Technician State Hospital	
	filled Hygi other	a)	17. Father's Name (First, Middle, Last)	
lan	Mental arked o	To B	0146	
Maryland	2 should and Men is marke eumatic	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
	and 2 leelth a m 27 is		Brenda W. Fleming/Daughter 4746 Bucktown Rd., Cambridge, MD 21613	
Baltimore	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Heelth and Mental Hygiene. Depertment of Heelth and Mental Hygiene. Importent: it item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Mudical Examiner must be notified at ance.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State	
<u><u>Ĕ</u></u>	Pag nent ent: t		'4 Donation 5 Other (Specify) Cokesbury Cemetery 8/27/2005 Reliance, MD	
alt	permit. Pag Depertment Importent: I any injury o		21. Supplaine of Funeral Service Licensee 22. Name and Address of Facility	
_	2011		Curran-Bromwell Funeral Home, P.A.	
			23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line. Approximation	tween
	Physician		Immediate Cause (Final disease or condition and Cardac Arrythmin and Car	Death 4 KeJ
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	
		20	Sequentially list conditions, b. Colonal Alter 10:58A5.e. 48A1.	<u> </u>
	ted nsit	Examiner	This wading to find additional and the form as a consequence of): cause. Enter Underlying Cause (Disease or injury	15
	al-tra	xar	that initiated events resulting in death) Last Due to (or as a consequence of):	
8760,	ate be executed thysicien and the burial-transit	icai E		15
9	law requires thet the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit			<u> </u>
Вох	teath certifica attending phy I for use as th	N/	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery	
	deat	icia	in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Yes 2 No 9 Unknown	Year
P.0	that the de ted by the s detached t	Physician/Med	9 □ Unknown	
	res the signed be det	by	Part II. Other significant contributing to death but not resulting in the underlying cause given in Part I.	leath?
ord	w requir been si should	ted	Empheseine Hypertersion Perile 20 No 3 Probably 4	Jnknown
Records,	a faw	Completed	Vasculas Disease Carotio actory Disease Diabetes, 24a. Was an autopsy prior to completion of	
	ysician: The faw is certificate has b director, page 2 s	Co		
Vital	Physician: rthis certific ral director.	Be	examiner?	
of	> .º 0	1. 70	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5 Fesidence 6 Other (Specify)	
O	ding f h. After funer	tion	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Work? 2 Accident investigation 28b. Time of 28c. Injury at 28d. Describe how injury occurred Work? 1 Yes 2 No	
Division	Attending it death.	fica	3 Suicide 6 Could not be determined determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number)	her
á	after 1 Dire	Certification:	4 Homicide building, etc. (Specify)	501,
	To the Hospitei or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral			
	he He in 24 he Fu	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(sample).)
	To t To t	Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
			1 / bis 9/1/a-1/10. H44610 8/25/05	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
			Dr. Lois Narr, 100 Bramble St., Cambridge, MD 21613 31. Date filled (Month, Day, Year) 32. Registrar's Signature	
	Sta Registi			

State of Maryland / Department of Health and Mental Hygiene 2005 1 - For State Registrar 29584 Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day **Physician** Maria Checchia /Medical August 10, 2005 5.462 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital **Olney** Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 M 200 Hours Yrs Director 578 52 2854 90 Feb. 13, 1915 Italy Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f show 1 Yes 2 No Directo Maryland Montgomery Silver Spring 10e. Street and Numbe 10g. Citizen of What Country? WIT 3704 Ralph Road by Funeral 20906 death USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 2 should be filled within 72 hours after and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No 3 ₩ Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Giuseppe Pompa Filomena Lerario 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mit. Pages 1 and 2 slowthean of Health and 27 is recreated to 18 them 27 is related to 18 the Mario Checchia / Son 19004 Festival Drive Boyds, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 9 8/15/2005 Silver Spring, Maryland 22. Name and Address of Facility Hines Rinaldi Funeral Home permit.
Deportre
Imports
any inju 21. Signature of Funeral Jer 11800 New Hampshire Ave Silver Spring, MD 20904 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Arrhythmia disease or condition resulting in death) 1 hour /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter undertying Cause (Disease or injury that initiated events resulting in death) Last 10 years Due to (or as a consequence of): Examiner certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes A ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? performed? 2X No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death Check onl one examiner Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? e Hospital or Attending P 24 hours after death. e Funeral Director: After t 28b. Time of Certification: 28d. Describe how injury occurred Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D006077 August 23, 2005 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and a Kerri Armon, M.D. 1801 Prince Philip Drive Olney Maryland 32. Registrar's Signature 5 AUG Registrar

December Name First, Mesos, Last Revin George Durm Serving Name First, Mesos, Last Reving Name Revin	2958	•	Mental Hygie						State of Maryla 28e, f per	nd Items	For Ameri State Registrar		/ 4						
Facility Name (if not institution, give street and number) 4s. City, Town, or Location of Death 4c. County of Death 4c. Coun	3. Time of Death		2. Date of Death								31.5								
Examines Control of Death Control of Death County of Death	11:30 A ^M	21, 2005	Äugust							ge Durm	Kevin Georg								
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Description		9. Birti Co	8. Date of Birth (Month, Day, Y	Min.															
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Specify only highest grade completed College (1-4or 5+) Student Stu	ntry?	Citizen of What Co	10g			Code	10f. Zip				10e. Street and Number	irec	288						
Specify only highest grade completed		USA			012	21			9	ee Drive	287 Raintre	a D	23a o						
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August Committed Committ	nh School							me.	College (1-4or 5+)	y (0-12)		m m	Pen .						
Manage M	, 501.501			her's Name		acric	Deu			. Middle, Last)			Hygie nt, E						
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23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, 1 any, leading to immediate cause. Enter Underlying Cause (Disease or injury resulting in death) Sequentially list conditions, 1 any, leading to immediate cause. Enter Underlying Cause (Disease or injury resulting in death) Due to (or as a consequence of): Due to (or as a consequence o			. 26,	Aug	1				amovai irom State	emation 3 Ren	1 ⊠Burial 2 □ Cred		nt of nt of r or o						
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25. Was case referred to medical 26. Place of Death (Check only one)	psy findings available mpletion of cause of	prior to death?	autopsy performe									Complete	The law rete hes be						
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29a. Certifier Second Sec	1)				4 🗆 🗅	JA			1 X Monpatient 2	no:			this c						
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier 29a. Certifier (Cneck only one) 29a.	color .		Oc. C	1					Month, Day Year		1 □Natural 5 □	io O	After						
determined	محددالق	,, -	201 Leasting (Street		TOS 4			45	8/20/95			cat	fleath death tor: ,						
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as s and manner stated.	Park, MD	tate) Severna	City or Town, S					fy)	building, etc. (Spe	determined		E	of A Mitter Direction by						
and manner stated.	ey Rd2114 tated.	e(s) and manner as	Ritchie F and due to the caus	and place,		at the tim	h occurred	owledge, deal	er: On the basis of exami		(Check only 2KD	licai Ce	Hospital 14 hours a Funeral I tely filled						
5 € 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month,	Day Year)	Date signed (Mont)	29d	r	e number	c. License	296		and manner stated.	of certifier -		Med	thin 2 the mple						
O.C.M.E. August 23,			1						mo	phei	290. Signature and the o	P 3 P 3							
	201	ryland 2.	imore, Ma	Balt	eet,	Stre		111	EKE, No	on lo	J. LAPO								
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 2 4 2005						D	Box	-			·								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Archie Dean Davis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Peninsula Nedical Center WICONILO Legional 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1**X** M 2□ F 214-30-9238 4/9/1929 Ocean City, MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in than "natural", or Items 23a or 28a-f ehore the Medical Examinar must be recitive at XX es 2 ☐ No Director Ocean City MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA by Funeral 10306 North Rd. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1950-55 1 Yes 2 No 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Hair Cutting Industry 8 Barber it of Health and Mental Hyg If item 27 Ia marked other or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Archie D. Davis Alice Jarvis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce T. Davis 115 Morris Mill Rd., Salisbury, MD 21804 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Depertment of Important: If any Injury or once. 4 Donation 5 Other (Specify) Sunset Memorial Pk. 8/28/2005 Berlin, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility The Ullrich Funeral Home 26a. Part. Enter the disease, or complications that cause the death. shock, or heart failure. List only one cause on each line. 10902 Ocean Gateway, Berlin, MD 21811 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between and Death Immediate Cause (Final **Physician** pration as disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): nding physician ause as the burial Box 68760, Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence Certification: To 2 ER/Outpatient 1 Yes 3 DOA this 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After I 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical (Check only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peninsula Regional Medical 8+1 E.T Silvia, B. Charles 31. Date filed (Month, Day, Year) State AUG 29 2005 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 29587 Certificate of Death 2. Date of Deeth 3. Time of Deeth 1 Decement's Name (First Middle Last) Year Month **Physician** DiUbaldo 5:54P.M Arone /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (ff not institution, give street end number) Examiner Westernport
If Under 1 Year | If Under 24 Hrs. | 8. Date of Months | Days | Hours | Min. | (Month Alleg. 105 Division St. Birthplace (State or Foreign Country) 6. Sev 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) 5. Social Security Number **Funeral** Months 1以M 2□F Yrs. 216-09-7996 Director 92 7-11-1913 MD Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Marylend nant of Health end Mentel Hygiene. Interest if them 27 is marked other than "natural", or thems 23a or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumetic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Funeral Director MD Alleq. Westernport 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 105 Division 21562 USA 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11 Merital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3altimore, Maryland 21215-0020 Specify: White Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Westvaco Elementary/Secondary (0-12) College (1-4or 5+) Fine Papers Foreman 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) if Health end Mentel I Andrew DiUbaldo Teresa DiSabatino 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 105 Division St., Westernport, MD 2156
of Disposition (Name of Date Doc. Location - City or Town, State Pansy DiUbaldo MD 21562 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ō St. Peter's Cem. mportant: i 8-30-05 **Jepertmani** 4 Donation 5 Other (Specify) Westernport MD 21. Signature of Funeral Sovice License 22. Name and Address of Facility Fredlock Funeral Home -31 Jones St. Piedmont, WV 26750 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical heimens Dementia Examiner Due to (or as a consequence of): Examiner lcian end burial-transit Hospital or Attending Physician: The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Box 68760. Completed by Physiclan/Medical Due to (or as e consequence of): 23b. Did tobecco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HTN Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? GI bleed Agitation 1 ☐ Yes 2 ☐ No 1 Yes 2 140 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4☐ Nursing Home 5 VHesidence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No Medical Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 5 Pending investigation Natural after death. 1 Tyes 2 □ No 2 Accident in by the 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide within 24 hours aft To the Funeral Dis completely filled in

Registrar

29a. Certifier

29b. Signeture end title of certifier

32. Registrar's Signature 31. Date filed (Month, Day, Year) OSEP 2005 - 1

30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

✓ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

		-	For State Registrar	State of M		d / Depa		t of H	ealth a			giene Reg. No.	201	05	29	588
	· 1		Decedent's Name (First, Middle, Last)								2. Date of De	ath Day	Va		3. Time of	Death
	Physicia		,Tc	seph T.	Drurs	7					Month August		200		2:32	A^{M}
1	/Medic Examin	40.00	4a. Facility Name (If not institution, give				4b. City,	Town, or	Location o	of Death			County of D	eath		
*	LXUIIII	٠.	5100 Gatehouse Way	Į.			E	Llia	ott C	ity				war		
	Funeral		5. Social Security Number 6. Sec	7. Ag	ge (In yrs.	last birthday)	If Under Months	1 Year Days	If Under:	24 Hrs. Min.	8. Date of Bird (Month, Da NOV 15	th y, Year)	9.	Birthpla Countr	ce (State or y) York	Foreign
-	Director	3	156 56 1084	S M 2□F	47	Yrs.	WOTHING	Days	110013		Nov 15	, 19	57	New	York	
	pu ,		Usual Residence of Decedent		10c Cit	y, Town or Lo	cation							10	d. Inside Cit	v Limits
	ahow	_	10a. State 10b. County												1 🗆 Yes	
	88-1	Sch	MD Howard		E	Llicot			_			10a Citis	en of Wha	Count	w2	
	ith th	5	10e. Street and Number				10f. Zip	210	12			-	nited			
	s 23s	by Funeral Director	5100 Gatehouse Way	12. Was Decedent	Suprin II	C 12	Mas Dagge			gin? (Sne	oify Ves or No		4. Race - A			
	er de Itami	nue	11. Marital Status	Armed Forces	?	.5.	If Yes, spec	of Cuba	n, Mexican	n, Puerto	ecify Yes or No Rican, etc.)		Black, V			
36	rs aft	S F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	310		1 ☐ Yes a	2XNo	Specify:				Specify:	W	nite	
8	72 hours after death with the Maryland natural; or Itams 23a or 28a-f ahow dical Examiner must be notified at	ed	15. Decedent's Edu	cation		16a. Dece	dent's Usua	il Occupa	ation			16b. Kir	nd of Busin	ess/Indu	istry	
15	n n	plet	(Specify only highest grad Elementary/Secondary (0-12)	e com <i>pleted)</i> College (1-4or	5.4	(Give	kind of wor DO NOT us	rk done d se retired	<i>durin</i> g mosi !)	t ot workii	ng					
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Þ	othe othe	Be C	17. Father's Name (First, Middle, Last)								(First, Middle,	Maiden	Sumame)			
<u>a</u>	Aenta Aenta rked tic e	ToE	Joseph Drury						Marg	aret	Home					
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Itam 27 is marked other than "natural", or itams 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (T)	γρe, Print)							d Route Numb					
	and 2 alth a		Michele M. Drury/	Wife							icott (
Ore	of He of He litem		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ F	Removal from State	20b. F	Place of Dispo cometery, cre	sition (Nan matory or o	ne of ther plac			ate		cation - City			
Ĕ	Page nent o ant: If ary or		'4 □Donation 5 □ Other (Specify)		St	. John					2005		.cott			
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		21. Signature of Funeral Service Licens	ee 1	M010	044 2	2. Name an	d Addres	s of Facilit	y Har	ry H. V	Vitzk	e's F	ami.	Ly FH	Inc.
0	Dep imp		Den Colla	s was	e	4	112 0	ld C	olumb	ia P	ike Ell	licot	t Cit			
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition			h. Do not en tic Co				cardiac c	or respiratory a	rrest,			Approximate Interval Bety Onset and D 9 mont	veen Death
	/Medical		resulting in death)	Due to (or as												
	Examiner		Sequentially list conditions,	b										-		
	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	s a conseq	luence or):										
	be executed icien and burial-transit	хаш	that initiated events resulting in death) Last	c Due to (or as	s a consec	uence of):		* * * * *						-		
760,	e be execul /sicien and e burial-trar	calE		200 10 (3. 0.		,0000										
687	physi the b			d									<u>.</u>			
9 ×	death certificate t e attending physic od for use as the b	Physician/Medi	IF FEMALE:	23c. If yes, outcome	e of preana	ancv							3d. Date of	f deliver	v	
Вох	atten for u	clan	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	il death 3	□Ectopic pr □ Other (sp						Month			ear ear
o.	0 0 7	yslo	1 □ Yes 2 □ No 9 □ Unknown	9☐ Unknown												
٥.	The law requires that the de tite has been signed by the a bage 2 should be detached f	/Ph	Part II. Other significant conditions co	ntributing to death	but not res	sulting in the u	inderlying c	ause giv	en in Part I	١.	23e. Did 1	obacco u	se contribu	te to the	cause of d	eath?
ds	uires sign ld be	d by									10	Yes 2	No 3	Proba	biy 4 □U	Jnknown
Ö	v require been si should b	Completed									24a. Was	an	24b. Wer	e autop	sy findings	available
Re	has ge 2	Ę.										ormed?	deat	th?	pletion of ca	ause of
a		e Co	25. Was case referred to medical						26 Place	of Death	1 Yes		1 🗆	Yes a	2[X No	
==	sicia certi	00	examiner?	Hospital:	ient 2	ER/Outpatie	nt 3 DC	Oth	05		me 5 ☑ Resi		S □Other /	Specify)	
Division of Vital Records,	Attending Physician: r death. ector: After this certific by the funeral director,	5. To	27. Manner of Death	28a. Date of Inj (Month, D		28b. Time o		28c. Injur Wor			28d. Describe			<i>Spoony</i> ,		
O	ding f th. : After funer	tlor	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D.	ay Year)	Injury	М		k? Yes 2□	No						
İSİ	i or Attene after death Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be	289. Place of II	njury - At h	ome, farm, st	reet, factory	y, office			28f. Location (or Rural	Route Num	ber,
ă	p h j	erti	4 Homicide	building, e	etc. (Speci	ny)					City or To	WII, SIAIB	,			
	To the Hospitel or within 24 hours afte To the Funeral Dir completely filled in	Medical C	29a. Certifier 1 X Certifying Phy (Check only one) 2 Medicel Exem	/sician: To the bes	of examina	owledge, dea ation and/or in	th occurred nvestigation	at the tir , in my o	ne, date ar pinion, dea	nd place, ath occurr	and due to the ed at the time,	cause(s) date and	and manne place, and	er as sta	ited. the cause(s)
	To the within 2	Me	29b. Signature and title of certifier	0.0	,	MA	290	c. Licens	e number			29d. Dat	e signed (A	Aonth, E	ay, Year)	
	⊢ s ⊢ ō		> Salurand	I he	e V			D236	501			Αιια	25,	200	5	
			30. Name and address of person who d	completed cause of	death (Iter	m 23a) (Type		2230				- 100	,,			
20	200		E. Lee 11065 Lit					lumk	oia, N	1D 21	.044					
-	St.	ate	31. Date filed (Month, Day, Year)	32. gis	trar's Sign	ature										···
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			1 - For State Registrar	State of Maryla		artment of F			giene Reg. NO 0	5 29589
			Decedent's Name (First, Middle, Last,)			Dodin	2. Date of De	ath	3. Time of Death
	Physici		Margaret	Elizabeth	DeFor	.d		Augus	t 29 200	
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)			or Location of Dea		4c. County of D	Death
			Genesis HealthC	are - The	Pines	Eas	ton		Tal	bot
	Funeral Director		212-00-1302]M 2√2F	rs. last birthday) Yrs.	If Under 1 Year Months Days		(Month, Da	th y, <i>Year)</i> 9. 21, 1953	Birthplace (State or Foreign Country) Maryland
	and *		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	daryla f eho	ō	Maryland Talbot		St. Mic					1 √Yes 2 No
	28e-	Director	10e. Street and Number			10f. Zip Code		· · · · · · · · · · · · · · · · · · ·	10g. Citizen of Wha	t Country?
	3e or		101 Miles Lane	Apt. 103		2166	53		Inited Sta	tes of Americ
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23e or 28e-f show other treumatic event. The Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XVidowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Sean, Mexican, Puer		14. Race - A Black, V	American Indian, Vhite, etc. UCasian
9	2 hou	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	pation		16b. Kind of Busine	
21215-0036	hin 7.	Completed	(Specify only highest grad	e completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of wo d)	rking		
2	giene giene er the	Com	9			Manage	er		Apart	ments
nd	d 2 should be filed within in and Mental Hygiene. 7 is marked other then "treumatic event, the Mac	Be (17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle	, Maiden Surname)	
Maryland	Ment arked	ို	Robert Jame					Rain Llo		
lar.	2 sho and is m		19a. Informant's Name/Relationship (T)	•					er, City or Town, Star	
	1 and 2 Health sem 27		April Longworth	Daughter	213 (b. Place of Dispo		Lane, Pi	neville,	Louisian	
Baltimore,	permit. Pages 1 and Department of Health Importent: If Item 27 eny injury or other to once.		20a. Method of Disposition 1 □ x urial 2 □ Cremation 3 □ F	Removal from State	cemetery, crei	natory or other pla	1		20c. Location - City	·
Ħ	permit. Pa Departmer Importent eny injury		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 		enton Ce	_	9/2/	2005	Denton, M	aryland
Ba	permit. Pages: Department of It Importent: If Ite eny injury or of once.		Kandofel !	. (Noone	Ŋ	Name and Address Noore Fur. 2 South	neral Hom Second S	treet. I	enton, Ma	ryland 21629
	Physician		23a. Part1. Enter the diserne, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line,	eath. Do not ent	er the mode of dyi	ng, such as cardia	c or respiratory a	rrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):					O -
		<u>_</u>	Sequentially list conditions,	Due to (or as a cons	equence of):					
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	cate be executed obysician and the burial-transit	xar	that initiated events resulting in death) Last	Due to (or as a cons	equence of):					
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89		edic								
P.O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pred 1 Live birth 2 For 4 Pregnant at time of 9 Unknown	etal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of Month	delivery Day Year
	ires that signed by d be deta	þ	Part II. Other significant conditions co.	ntributing to death but not r	esulting in the u	nderlying cause gr	ven in Part I.			e to the cause of death? Probably 4 Onknown
Ö	requ	etec	n.50.1	- in 11 + 11				- II		
Il Records,	The lay ate has page 2	Completed	Franci	Mento.	>			24a. Was autor perfo	osy prior deatl	autopsy findings available to completion of cause of 1? Yes 2 \(\sumbolear\) No
Vital	cien: ertific	Be	25. Was case referred to medical examiner?	la anital.			2	ath (Check only o	one)	
of	d is	မ	1 Yes 2 No		☐ ER/Outpatier	I 3 DOA			dence 6 Other (5	Specify)
n	ding f	lo lo	1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	rk?]Yes 2 □No	28d. Describe	how injury occurred	
Sign	Attending or death. ector: Atterby the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - Al	thome farm str		163 2 110	28f Location (Street and Number of	r Rural Route Number.
Division of	lor A after Direct	Certification:	4 Homicide determined	building, etc. (Spe	cify)	cot, ractory, office		City or To		Tida Tioste Namber,
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, deatlination and/or in	occurred at the tile vestigation, in my o	me, date and place	e, and due to the urred at the time,	cause(s) and manner date and place, and	r as stated. due to the cause(s)
	o the lithin o the omple	Me	29b. Signature and title of certifier	and marifier stated.		29c. Licens	se number		29d. Date signed (M	onth, Day, Year)
	F ≥ F 8		1 Aussell	a. Silvi		H4.	2587		1941791-	2006
			30. Name and address of person who co		tem 23a) (Type	Print)			01211	VV 5
			Russall A Schill	n, 80 555	Gwoa		ton ms	21601		
	Sta Regist		31. Date filed (Month Day Year) 2005	32 Registrar's Sig	gnature	and I				

Margaret Deford

tk Indelible Ink. Ensure All Copies Are Legible.
Department of Health and Mental Hygiene
10/06/05dhb
Certificate of Death
Reg. No. 200 Amend Please Type or Print in Bla 1- State Amend Item 28f per Dr., G848, 10 Reg. No. 2005 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Hazel G. Duva11 2005 7:00pM August 26, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Severna Park Center Severna Park Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth (Month Day, Year) 11/15/18 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 😿 F 86 217-18-6890 Director Yrs Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or itams 23a or 28a-f show Federalsburg Caroline Director MD 1 Yes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country?
United States 21632 6031 Federalsburg Highway death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: White 3X Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame)
Sarah Caperoon 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fil ment of Health and Mental H tant: If itam 27 fs marked oth Frank Caperoon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy F Duvall, Sr./Son 41 Snellings Court, Severna Park, MD 21146 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 6 permit. Page Department of Important: If any injury or once. Eastern Shore Veterans Cem 08/29/05 Hurlock, Maryland * 4 □ Donation 5 □ Other (Specify) 22 Name and Address of Facility Framptom Funeral Home, P.A 216 N. Main St., Federalsburg, MD 21632 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Dua to (or as a consequence of) burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical the IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Year 4☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown à signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ PELVIC FRACTURE 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed FRACTURE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No Vital 1 ☐ Yes 2 ☐ No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Division of 27. Manner of Death 28a. Date of Injury (Minth, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred or Attanding After 1 Natural 5 Pending investigation death. 2 Accident 3 Suicide 10/2005 1 ☐ Yes 2 XNo RIPPED AND FELL AT HOME Director 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) Severna Park, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 determined 4 Homicide Nursing HOME within 24 hours a To the Funeral I 24 Truck House Rd., Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 0 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) KILBRIDE RD Registrar's Sig State Registra

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Phebe Falcone 8 24 2005 2:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7 Essex Court Ocean Pines Worcester If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) July 23, 1 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X F Director Yrs 159-32-5561 65 1940 PA Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Exacting natal be notified at Director 1 Yes X No Worcester MD Ocean Pines 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 or Items 23a 7 Essex Court 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ۵ Specify: 3 ☐ Widowed 4 ☐ Divorced White "naturel", Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) t and 2 shoutd be filed within ? Health and Mental Hygiene. 3m 27 Is marked other then " Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant **Telecommunications** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gilmore Merle Montgomery Maude Peace Burgess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pagas 1 and 2 Department of Health an Important: If item 27 Is any injury or other trau once. John Falcone (husband) 7 Essex Court, Ocean Pines, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) Cape Henlopen Crem. 8/24/2005 Frankford, DE 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 William St., Berlin, MD 21811 22a. Part1. Enter the disease, or complications that cause the shock, or heart failure. List only one cause on each line Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) 10 Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner is: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year P.O. 1 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1¶Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the Funeral Director: Afronthe Funeral Director: Afronthe Funeral Director: Afronthe funeral by the funeral brothe funeral 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0056776 8/26/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 145 E. Carroll St., Salisbury, MD 21802 Robert L. Clinton, M.D. 31. Date filed (Month, AUG 2 9 2005 32, Redistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2005 29592 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Marquerite Year Maxine Footen September 4,2005 3:45 MM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** SACRED CUMB CUMBERLAND
If Under 1 Year | If Under 24 Hrs. 8. D 4EAR+ ALLEGANY 5. Social Security Number 8. Date of Birth (Month, Day, May 15 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** Days 1 M 200F 215 - 26 - 9221 75 Yrs. Director Usual Residence of Decedent with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits **show** in then "netural", or items 23s or 28e-f show the Medical Examinar must be cotified at MD. Allegany Rawlings 1 ☐ Yes ŽÃ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24404 Pine Hill Road United 21557 States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filled within 72 hours after to Department of Heelth and Mental Hygiane. Important: If Item 27 is marked other then "netural", or Item any injury or other treumetic event 1 Never Married 2K Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2KNio þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Uousework Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John McKenzie Eva Tanner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas J. Footen/son 24432 Pin Hill Road, Rawlings, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 09/05/ 2005 1 ☐ Burial 2XX remation 3 ☐ Removal from State Cumberland Maryland Cumberland Crematory 14 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licensee 111 Church St., Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each list. Approximate Interval Between Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a lonsequency of):/ acquired Prearone Examiner Communit ay Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an @ JUNGAY has certificate 2 No 1 ☐ Yes Division of Vital or Attending Physicien; 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 10 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day 28b. Time of 27. Manner of Death 1 Natural 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: in by the 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct completely filled in by 4 \(\text{Homicide} \) To the Hospitef 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certified KG116 Nas 30. Name and address of pers who who ed cause of death (Item 23a) (Type, Print) Oldtown Rd, Cumberland, Mil MAny Man Na caratnam
31. Date (fled (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Fauble Anna Mav 29, 2005 <u>August</u> 11:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Vindobona Nursing Home Braddock Heights Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 💢 F 217-32-6793 Director 71 Yrs. 10, 1934 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Madical Experiment was be notified at 1 ☐ Yes 🏋 ☐ No Maryland Frederick Braddock Heights Directo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6012 Jefferson Blvd. 21714 U.S.A. s 1 and 2 should be filed within 72 hours after death wi f Heatth and Mental Hygiene. Item 27 is marked other than "natural", or Itema 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Carrie Eva Revnolds Wilbur Harner Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanne Lou Schaeffer, daughter 431 Carlisle St., Hanover, PA 17331 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State Smithsburg Crematory Sept. 1, 2005 Smithsburg, MD ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses ^{22. Name and Address of Facility}
Keeney and Basford PA Funeral Home
106 East Church St., Frederick, MD M00255 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat Carrinoma Kena Physician disease or condition resulting in death) YEAVS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause . Enter Uncertain Cause (Disease or injury Due to (or as a consequence of): Examine burial-transit law requires that the death certificate be executed that initiated events the attending physiclen and Division of Vital Records, P.O. Box 68760. 🖈 resulting in death) Last Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Mell 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after of Funeral Direct 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 22037 August 29, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leonard C. Kinland, M.D., 610 Ninth Ave., Brunswick, Maryland 21716 31. Date filed (Month, Day, Year) 32 Registrar's Signature Registrar 9 2005

			For State Registrar	State of	Marylan	d / Depa	artment o	of He	alth and <i>eath</i>	Mental Hy	giene 2	005	29594
	Physici		Decedent's Name (First, Middle Naomi		lson	Fitz	Gibbon			2. Date of De Month August		005 ^{Year}	3. Time of Death 4:55pm M
	/Medio		4a. Facility Name (If not institution Frederick M	n, give street and numb	oer)	1102	4b. City, To	wn, or L	ocation of De		4c. Cou	nty of Death	
	Funeral Director		5. Social Security Number 577-34-2786		Age (In yrs. 77	ast birthday) Yrs.	If Under 1	Year I	f Under 24 H Hours Mi		h	9. Birtho	olace (State or Foreign oyland
	e Maryland le-f show	ctor	Usual Residence of Decedent 10a. State Maryland Trede	rick	10c. City	y, Town or Lo Frede		-				1	0d. Inside City Limits 1 X Yes 2 No
	3e or 26	I Director	10e. Street and Number 2223 West Gree	nleaf Driv	e		10f. Zip Co	ode	217	02	10g. Citizen o	U.S.A	•
036	2 should be filed within 72 hours efter death with the Maryland and Mental Hygiene. Is marked other than "natural", or itams 23e or 28e-f ehow aumstic event, It's Medical Evara' ar must be tradified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	If Yes Give	es? ⊠No		Was Decedent f Yes, specify 1 ☐ Yes 2 ∑		anic Origin? Mexican, Pu	(Specify Yes or No erto Rican, etc.)	- 14. F B	lace - Americ lack, White,	
Maryland 21215-0036	within 72 hou ene. then "natura re Medical E	Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12)	t's Education st grade completed) College (1-4	or 5+)	(Give	dent's Usual C kind of work of DO NOT use act Adi	done dur retired)	ring most of w			Business/In	dustry ncer Inst
yland 2	ould be filed Mental Hygi arked other ktic event, I	To Be Co	17. Father's Name (First, Middle, Paul Erdma		son					ame (First, Middle,			
	Jes 1 and 2 sho i of Health and if itam 27 is m or other traum		19a. Informant's Name/Relations Mr. Donald Fit 20a. Method of Disposition 1 □ Burial 2 ☎ Cremation	zGibbon- Hu	20b. P	2223 lace of Dispo	West sition (Name matory or other	Gree of er place)	enleaf	Date	rederio	ck, Ma	ryland 2170 own, State
Paul Erdman Tolson Naomi Watson 19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 21c. Signature (Euneral Service License) 22c. Name and Address of Facility Keeney & Basford P.A. Funeral Home M00706 106 Fast Church St, Frederick, Maryland 217													
8760, 🗡	The law requires that the death certificate be executed The has been signed by the attending physician and unique to should be detached for use as the burial-transit	dical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (a	sed the death hine. Spirat as a consequence as a consequ	ion Pnuence of):	er the mode o	of dying,	such as card	ac or respiratory ai	rest,		Approximate Interval Between Onset and Death 2 weeks
.O. Box 6	at the death certific by the attending p tached for use as i	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		h 2∏Fetal nt at time of de	Ideath 3	Ectopic preg Other (speci				1	Date of delive Month	ory Day Year
rds, P	w requires that been signed t should be deta		Part II. Other significant condition Rheumatoid Ar		th but not rest	ulting in the u	nderlying caus	se given	in Part I.		obacco use co ′es 2 🛱 No		ne cause of death?
Vital Records,		3e Completed	Hypertrophia Hypertension: 25. Was case referred to medical	Hyperthyro				2	6. Place of D	24a. Was autop perio 1 Yes	med? 2 X No	prior to cor death?	psy findings available npletion of cause of 2 No
1 X Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Othe												()	
Divi	i Dir	Certification:	3 Suicide 6 Could determ	nined 286. Place of building	f Injury - At ho s, etc. <i>(Specif</i>)	v) 				City or Tox	rn, State)		l Route Number,
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in It	ledical	(Check only 2 Medical one)	ng Physician: To the bi Exeminer: On the bas and manne	is of examinat	wledge, death tion and/or in	vestigation, in	my opin	ion, death oc	curred at the time,	date and place	e, and due to	the cause(s)
}	To vith	W	29b. Signature and Itle of certifie	5.	lan	MI	/ 1	D164			29d. Date sign Augus t	-	
	10			e, III, M.I	D., 300	0 West	Ninth	Str	eet, F	rederick	, Mary	Land 2	17 0 1
	Sta Reĝisti		31. Date filed (Month, Pay, Year)	2005 3 Reg	gistrar's Signa	Ture Contract	relie						

			1 - State of M	aryland / Dep <i>Ce</i>	artment of H	lealth and N Death		giene2 Reg. No.	005	29595
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of De Month		Year	3. Time of Death
	/Medic		Robert Alan Fo				August	<u>.</u>	2005	2:50A M
	Examin	er	4a. Facility Name (If not institution, give street and number)			Location of Death		1	unty of Death	
			27363 Hobbs Road	- A- t- t- t- t- t- t-	Dento		I (D:		arolir	
	Funeral		5. Social Security Number 6. Sex 7. Ag 1	ge (In yrs. last birthday Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da	4,195	9. Birthr	place (State or Foreign ary) aryland
Н	Director		Usual Residence of Decedent	50 "			May I	4,15.	73 110	ir y rana
	yland now		10a. State 10b. County	10c. City, Town or L	ocation				1	0d. Inside City Limits
	Man a-f sh	to	Maryland Caroline	Denton						1 ☐ Yes 2 ☐ X ¶o
	h the	Director	10e. Street and Number		10f. Zip Code			10g. Citizen	of What Cou	ntry? America
	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23e or 28e-f show event, the Medical Evanting runst be indiffed at		27363 Hobbs Road		21629			Unite	d Sta	tes of
	ems ems	Funeral	11. Marital Status 12. Was Decedent Armed Forces?		Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No		Race - Americ Black, White,	
õ	or It		1 Never Married 2 Married 1 ☐ Yes 2 ☑ If Yes Give		1 ☐ Yes 2 € No	Specify:	7 110011, 010.,		ecify:	etc.
9500-6121	hours after tural', or Ite	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:						Cauca	
۲ ک	"nat	Completed	15. Decedent's Education (Specify only highest grade completed)	(Givi	edent's Usual Occupa e kind of work done o DO NOT use retired	during most of work	ting	16b. Kind o	of Business/In	dustry
7	filed within 72 Hygiene. Ither than "nat	шb	Elementary/Secondary (0-12) College (1-4or	5+)	Mechani			Truc	kina	Company
0	filled Hygi other		12 HS grad 17. Father's Name (First, Middle, Last)		Mechani	18. Mother's Nam	e (First, Middle			company
land	ild be lental ked o ic eve	To Be	Roland Francis F	ountain		Kather	ine Ma	rie G	ardne	r
Mary	2 should be and Menta Is marked eumatic ev	-	19a. Informant's Name/Relationship (Type, Print)		ing Address (Street a					
_	2 6 7 5		Dona P. Fountain Wife	27363	B Hobbs Ro	ad. Dento	on. Mar	vland	21629	
ē,	- I = =		20a. Method of Disposition	20b. Place of Disp		1	Date		on - City or To	own, State
Ë	Pages nent of int: If it		Male Surial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify)	Denton (ຶ່ ¦9/1/:	2005	Dento	n, Mar	yland
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licensee	2	Name and Address Noore Fune	ss of Facility	D 7			
n	80 5 6 8		Kaucopef (None	I	12 South S	econd St	reet. D	enton.	Marvla	and 21629
			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each I	d the death. Do not er	nter the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Pnysician :	į, n	Immediate Cause (Final disease or condition	Calon (ancer -					Onset and Death
9	/Medical		resulting in death)	a consequence of):	Se Vicos					Syears
	Examiner	L	Sequentially list conditions, b.							
	ed sit	Examiner	if any, leading to immediate Cause (Disease or injury) Due to (or as	a consequence of):						
	and and I-tran	хап	that initiated events c.	a consequence of):						
8/60,	The law requires that the death certificate be executed to have been signed by the attending physician and page 2 should be detached for use as the burial-transit		350.15 (5).45	2 557755 517.						
98	icate phys s the	edical	d							
Box	eath certific attending p	/We	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome					23d	Date of delive	any
ň	death a atter	ciar	in the nast 12 months?	ast 12 months?						Day Year
o	at the de by the	Physician/Me	9 Unknown							
ري. ت	es that igned b	by P	Part II. Other significant conditions contributing to death t	out not resulting in the	underlying cause give	en in Part I.	23e. Did t	obacco use	contribute to the	ne cause of death?
ğ	w require been sig should b						1 🗆 '	Yes 2□N	o 3∏Prob	ably 4 Unknown
Records,	aw re as be	Completed					24a. Was		4b. Were auto	psy findings available mpletion of cause of
		E O					autoj perfo	ormed2 20 No	death?	,
Vital	ysician: Th is certificate director, pag	Be (25. Was case referred to medical examiner?			26. Place of Deat	h (Check only o			
ot V	Physician: this certific ral director,	2	1 ☐ Yes No Hospital: 1 ☐ Inpati		ent 3 DOA Othe	er: 4 🗆 Nursing Ho	ome Nesi	dence 6	Other (Specif	y)
Ē	ding P	on:	27. Manner of Death 28a. Date of Injury (Month, De (Month, De (Month))	ury 28b. Time (lnjury	Worl	ζ?	28d. Describe	how injury oc	curred	
Division	tend death tor: /	icat	2 Accident investigation 3 Suicide 6 Could not be			Yes 2 ☐ No	2011			
≥	or Al	Certification;	determined 288. Place of III	ijury - At home, farm, si tc. <i>(Specify)</i>	treet, factory, office		City or To	Street and Ni wn, State)	umber or Rura	l Route Number,
_	spitel		29a. Certifier Certifying Physician: To the best	of my knowledge, dea	th occurred at the tim	a date and place	and due to the	221122(2) 222	l manage as a	totod
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only 2 Medical Examiner: On the basis one) and manner st	or examination and/or ii	nvestigation, in my of	pinion, death occur	red at the time,	date and pla	ce, and due to	the cause(s)
	To th Withir To th	Me	29b. Signature and title of certifier		29c. License	a number		29d. Date si	ned (Month,	Day, Year)
			* * * * * * * * * *	>/)	to	17497		×/	30 00	5
			30. Name and address of person who completed cause of	death (Item 23a) (Type	, Print)	1112		3/	~ 10-	
				Cynwood Dri	ive, Easto	n, Maryla	and 2160	01		
		ate		rar's Signature	_					
	Regist	rar	LOG 9 T COOL	no labore	0.00					

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State of Maryland / Department of Health and Mental Hygiene

			1- State of Maryland / De State of Maryland /	partment of Health and Mental Hygiene C847, 09,08,05dhb erillicate of Death Reg. No.2 11 15 2050 6
	Physici		1. Decedent's Name (First, Middle, Last) NELLIE G FREELAN	2. Date of Death Month Day Year 7.00 Month Month Mo
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 223318 Highrock	4b. City, Town, or Location of Death Rawlings 4c. County of Death Allegany
	Funeral Director		5. Social Security Number 236-36-1278 6. Sex 1 M 2 M F 97 Yrs. 1 ast birther 1 M 2 M F 97 Yrs. 1 Security Number 1 M 2 M F 97 Yrs. 1 M 2 M F 97 Yrs. 1 M 2 M F 97 Yrs. 1 M 2 M F 97 Yrs. 1 M 2 M F 97 Yrs. 1 M 2 M F 97 Yrs. 1 M 2 M F 97 Yrs. 1 M 2 M F 97 Yrs. 1 M 2 M F 97 Yrs. 1 M 2 M F 97 Yrs. 1 M 2 M F 97 Yrs. 1 M 2 M F 97 Yrs. 1 M 2 M F 97 M 2 M 2 M F 97 M 2 M 2 M F 97 M 2 M 2 M F 97 M 2 M 2 M F 97 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M	y) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. (Month Day Year)
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Hampshire 10c. City, Town of Spr	Location ngfield 10d. Inside City Limits 1 □Yes 2□No
	a or 28a	Funeral Director	10e. Street and Number HC 65 Box 3710	10f. Zip Code 10g. Citizen of What Country? 26763 USA
980	d within 72 hours after death with the Maryland jiene. r than "natural", or Items 23a or 28a-f show the Madical Examinar must be indiffied at	þ	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Sive Yes, Sive Year or Dates:	3. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 □ No Specify: Specify: white
21215-0036	d within piene. r than	Completed	(Specify only highest grade completed) ((C) Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation ve kind of work done during most of working b. DO NOT use retired) Compared Own Home
Maryland ?	ges 1 and 2 should be filed it of Health and Mental Hygis it item 27 is marked other or other traumatic event, II	To Be C	17. Father's Name (First, Middle, Last) Howard Crossland	18. Mother's Name (First, Middle, Maiden Sumame) Lillian (Flanagan) Crossland
	and 2 shored and N m 27 is mather trauma		19a. Informant's Name/Relationship (Type, Print) Harold VanPelt son 22	ailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3318 Highrock Rawlings MD 21557
Baltimore,	Pages 1 au nent of Hea int: If item iry or othe		cemetery,	position (Name of rematory or other place) Park Date 20c. Location - City or Town, State
Balti	permit. Page Department Important: ti any injury or once.		21. Signature of Funeral Service Licensee	^{22. Name and Address of Facility} Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502
	Physician /Medical Examiner	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	
s, P.O. Box 68760,	res that the death certificate be executed igned by the attending physician and be detached for use as the buriat-transit	by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the past 2 12 12 13 14 15 15 15 15 15 15 15	3 Ectopic pregnancy 5 Other (specify) a underlying cause given in Part I. 23d. Date of delivery Month Day Year 23d. Date of delivery Month Day Year
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Division of Vital F	ending Physician: eath. or: After this certifics the funeral director, t	Certification: To Be Co	25. Was case referred to medical examiner? 1	1 Yes 2 No 1 Yes 2 No
	To the Hospitat or Att within 24 hours after d To the Funeral Direct completely filled in by i	Medical Ce	(Check only one) 2 Medical Examiner: On the basis of examination and/one) and manner stated. 29b. Signature and title of certifier	path occurred at the time, date and place, and due to the cause(s) and manner as stated. r investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number D0058863 29d. Date signed (Month, Day, Year)
	St: Regist	ate	30. Name and address of person who completed cause of death (Item 28a) (T. 51e/c)	

			1 - For State Registrar	State of	Marylan				d Mental H	ygiene Reg. No.	200	5	2959
				.ast)							Vons	3. Ti	me of Death
			MARLYN		PLAC:	IDE	GLAD]	DEN				9:	40 P M
			4a. Facility Name (If not institution, g	ive street and nun	nber)		4b. City, Town, or	Location of D	Death	4c.	County of Dea	th	
			102 Sycamore										
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	or 28	Dire					10f. Zip Code						
	s 23a	ral											
36	rs after de I', or Items	oy Fune	1 Never Married 2 Married	Armed For 1 ☐ Yes If Yes, Giv	ces? 2 Z No e				? (Specify Yes or Nouerto Rican, etc.)		Black, Whi	te, etc.	
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.O. Box	0 0 0	ysiclan/h	23b. Was decedent pregnant in the past 12 months?	1□Live b 4□Pregn	rth 2□Feta ant at time of d	Ideath 3				2			Year
Δ.	that the post of t	y Ph	Part II. Other significant conditions	contributing to de	ath but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco us	se contribute to	the caus	e of death?
rds	quires n sign								_ 12	Yes 2]No 3∏P	robably	4 Unknown
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Ω	after Direc	ertif					еет, тастогу, опісе				i ivumber or A	urai moute	Numper,
	spita nours nerel		29a. Certifier 1 Certifying	Physician: To the	best of my kno	wledge, death	occurred at the tim	ne, date and p	lace, and due to the	cause(s)	and manner as	stated.	
	ne Ho ne Fui sletely	edic	(Check only 2 Medical Ex	aminer: On the ba	isis of examina	tion and/or inv	estigation, in my op	oinion, death o	occurred at the time	, date and	place, and due	to the car	use(s)
)	To the within to the comp		29b. Signature and title of certifier	ouid	Suc	>	29c. License	number 3	38	9/6	1200	5	
	6		30. Name and address of person who Stuaut E.	o completed caus		n 23a) (Type,	900 P	estac	He Ra.	A	инар	ોાડે,	ma,
	Sta	_	31. Date filed (Month, Day, Year)	32. 9	egistrar's Signa	ture							
	Registr	ar	SEP 1 2 2	2005	gues de	1. So	and I			**			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Aug. 18, 2005 Larry Paul Gadow 5:40 рм 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 6690 Bell Creek Road Preston Caroline If Under 1 Year | If Under 24 Hrs. | 5 Social Security Number 8. Date of Birth (Month, Day, Year) 03/29/51 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1**1** M 2□ F Hours Min 54 Yrs. 218-58-0178 Maryland Usual Residence of Decedent 10c. City, Town or Location 10h Count 10d. Inside City Limits Caroline Preston 10f. Zip Code 10g. Citizen of What Country? 21655 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Laborer Poultry Company 18. Mother's Name (First, Middle, Maiden Sumame) Evelyn Lucille Harding 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6690 Bell Creek Rd., Preston, MD 21655 20c. Location - City or Town, State

MD 1 Yes 2 No Director 10e. Street and Number 3428 Linchester Road Completed by Funeral 11 Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Be Richard Paul Gadow 19a. Informant's Name/Relationship (Type, Print) Linda Fairbanks/ Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 08/18/05 Anatomy Gifts Reg. `4

Donation 5
Other (Specify) Hanover, Maryland 22. Name and Address of Facility Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632 St., Federalsburg, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final astatic disease or condition resulting in death) Due to (or as a consequence of):

Physician /Medical Examiner

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After

Director:

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Examiner

Physician/Medical

Be Completed by

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Certification:

Medical

Department of Health a importent: If item 27 is any injury or other tree once.

Physician

/Medical

Examiner

10a State

Funeral

Director

7 ie markad other then "natural", or items 23e or 28e-f shot treumatic event, Ite Musical Experiment rust be nutified at

Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. Int: If item 27 ie markad other then "natural", or Iter

Baltimore, Maryland 21215-0036

death with the Maryland

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

uce Due to (or as a consequence of)

IF FEMALE

23b. Was decedent pregnant in the past 12 months?

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death

3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify)

23d. Date of delivery Month

Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performe

2 2000 1 Yes 26. Place of Death (Check only one,

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 → Yo

25. Was case referred to medical examiner' 1 ☐ Yes 2 😿 6 27. Manner of Death

1 Accident

3 Suicide

4 | Homicide

31. Date filed (Month, Day,)

28a. Date of Injury (Month, Day Year) 5 Pending

Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Cther: 4 Nursing Home 5 Residence 6 V O er (Specify 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier sus a

investigation

6 Could not be determined

Bramble ST

29d. Date signed (Month, Day, Year)

e and a ress of person the co ho completed cause of death (Item 23a) (Type, Print) D.O.

32. Registrar's Signature

State Registrar

2 2005



law requires that the death certificate be executed o Hospitel or Attending Physicien: Division

			For State Registrar	State of M	larylan	id / Depa <i>Cei</i>	artment rtificate	of Hea	ith and i ath	Mental Hy	giene Rea. No	2005	2959	3 9
		175	Decedent's Name (First, Middle, L.							2. Date of De	ath		3. Time of Death	
8	Physici /Medio		EARL V GLAZE							Month AUGUST	25	y Year 2005	6:40 P	М
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			FREDERICK MEMOR			1 A b : ab 1 1	FREDE		Index 04 Lin			FREDERIC		
	FuneralDirector	i.	5. Social Security Number 6. 216-22-8666	Sex 7. A 1⊠M 2□F	98 (In yrs.) 88	last birthday) Yrs.	If Under 1 Months		Under 24 Hrs. ours Min.		ıy, Year)		nplace (State or Forei untry) vland	gn
	pug *		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	eation						10d. Inside City Limi	10
	Aaryli enho	ō											1 ☐ Yes 2 ☐ N	
	28a-	Director	Maryland Montgot 10e. Street and Number	mery	CI	.arksbu	10f. Zip C	ode			10a. Cit	izen of What Co		
	3a or		25329 Burnt Hi	11 Road			208				3	U.S.A.	,-	
	death	Funerai	11. Marital Status	12. Was Decedent	Ever in U.	.S. 13.	Was Decede	nt of Hispan	nic Origin? (S	pecify Yes or No		14. Race - Ame		_
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f ahow any injury or other traumatic event, If a Medical Exacts are restilised at once.	by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tyes 2 X If Yes, Give Year or Dates:	No		ir Yes, specify 1 ☐ Yes 2		exican, Pueri pecify:	o Rican, etc.)		Specify: White		
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Baltimore,	neit. I partm sortal / Injui		21. Signature of Fur ral Service Lice) 22	. Name and	Address of	Facility	(S)				u
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ŏ	death certifii e attending i ed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			Testania avas				2	23d. Date of deli	rery	
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ō	a Phy er this eral d	n: To	27. Manner of Death	28a. Date of Init	urv	ER/Outpatien 28b. Time of		: Injury at Work?	∐ Nursing H	ome 5 Resid			fy)	
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Division of Vital Records,	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	286. Place of in	jury - At ho tc. (Specify	ome, farm, stre	eet, factory, c	office		28f. Location (S City or Tow	Street and vn, State	d Number or Rui	al Route Number,	
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Att completely filled in by the fun	cai Ce	29a. Certifier 1 Certifying P	hysician: To the best	of my know	wledge, death	occurred at	the time, da	ate and place	, and due to the	cause(s)	and manner as	stated.	
	the H in 24 the F the F	fedical	57.6)	miner: On the basis of and manner si	tated.	HOLL AFTOVOR (DV								
	Vitl To COIT	Σ	29b. Signature and title of certifier	1/1				License num				e signed (Month		
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•	'5		30. Name and address of person who										_	
y (3)	Sta	ie.	Gaffar A. Syed,	32. Regist	r Signat	ture			uite 2	• Frede	rick	, Maryl	and 21701	
	Registr		ALIG 2	9 2005	Dallace	. K	Some	61						

State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death Reg. No. Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 05:35 AM September Irene Mae Hart 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Funeral^{*} 1□M 2♥F September 5,1938 Director 219-36-3306 MD Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 23a or 28e-f ehow other traumatic event, the Madical Examinar must be nutified at 1 ¥ Yes 2 □ No Director Washington Hancock 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21750 116 Fairview Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or Items 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Ite any injury or other traumatic event, Ita Medical Examina. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Domestic <u>Housekeeper</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Olive Myers Carlton Parker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 116 Fairview Drive Hancock, MD 21750 Alonza L. Hart/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Parkhead Cemetery 09/08/05 Big Pool, MD 4 Donation 5 Other (Specify) 21 gnature of Fu eral Service Licensee 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** monThons Padonehic (week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner ete has been signed by the ettending physicien and pege 2 should be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No 2 No 1 Tes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending To the Hospitel or Attendir within 24 hours after death. To the Funerel Director: At 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cumpletely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number on ano completed cause of death (Item 23a) (Type, Print) redical Compus Michae neck 31. Date filed (Month, Day, Year) 32. Paistrar's Signature State 2005 Registrar

			. For	State of Ma	ryland / D	epartm	ent of H	lealth a	and Me	ental Hyg	giene	21	105	296	0 1
			= State Registrar			Certific	ate of l	Death			109.110.	2 0	000		
П	Physicia	an.	1. Decedent's Name (First, Middle, L.							Date of Dea Month	Day		Year	3. Time of Deat	
	/Medic	al	Donald Albert H							August		County of	2005	12:20 p	<u> </u>
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	3,0		Usual Residence of Decedent											-	
	arylan ahow	_	10a. State 10b. County		10c. City, Towr	n or Location							10	d. Inside City Lin 1 ☐ Yes 2 ☑	
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	with ti	ă	10e. Street and Number 605 Rivendell Ct			107.	Zip Code	110			rog. Citiz			ıyı	
	death with the Maryland ma 23a or 28a-f ahow r must be notified at	Funeral Director	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was De		146 lispanic Ori	gin? (Spec	ofy Yes or No- lican, etc.)	. 1	14. Race	JSA - America		
	r item	핊	1 Never Married 2 Married	Armed Forces? 1 XYes 2 □ N						lican, etc.)			k, White, e		
Ö	within 72 hours after ene. than "natural", or ite ite Wedical Exercit	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1982	1 L Ye	2 X No	Specify:				Specify:	Whi	Le 	
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Maryland 21215-0036	d is a	To Be		Haines				Fl	oreno	e Ma	у :	Bate	eman		
ary.		۲	19a. Informant's Name/Relationship	(Type, Print)	19b	. Mailing Add	ess (Street	and Numbe	er or Rural	Route Numbe	er, City or	Town,	State, Zip	Code)	
	1 and 2 s Health ar tam 27 is		Christine Carey	Haines/Wife	2	605 Ri	vende	11 Ct		Severn	a Pa	rk,	MD 2	1146	
ore	of He of He fitam r oth		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3	□Removal from State		y, crematory	or other plac		Aua.	26,			City or Tov		
Ē	Pages ment of ant: If it		`4 □Donation 5 □ Other (Spec	ify)	Our La	ady of			200)5	Mil	lers	sville	e, MD	
Baltimore,	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other once.		21. Signature of Funeral Service Circ	Bern		Barr 495	and Address anco Gov.	ss of Facilit & Son Ritch	s, P. ie Hv	A. Se	vern	a Pa	irk Fi	uneral H MD 21146	cme
H	-11		23a. Party Enter the disease, or co shock, or heart failure. List on	mplications that caused	the death. Do r							<u>u . </u>	•	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	y 0/10 cause 0/1 bac/1 (6)		LUNO	Cav	rcev						Onset and Death	
	/Medical		resulting in death)	Due to (or as a	a consequence	of):								2 443	
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Вох	h cert endin use	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		3 ∏Ectop	c pregnancy	,			2	_	e of deliver		
B	e deat	sicis	in the past 12 months? 1 Yes 2 No	4 ☐ Pregnant at 9 ☐ Unknown		5 Other		,				Mon	ו ווווי	Day Year	
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Vital		0	25. Was case referred to medical					26. Place	e of Death	(Check only o	ne)	<u> </u>	☐ Yes	2 140	
	> 50 0	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nt 2□ER/Ou	utpatient 3	DOA Oth	er: 4 Nu	ursing Hon	ne 5 Resid	dence 6	5 Othe	er (Specify)	
0 1	ng Ph fter th neral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Da)		Time of njury	28c. Injur Wor	ry at rk?	2	8d. Describe h	now injun	y occurre	ed		
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Division of	af or Attending P safter death. I Director: After t d in by the funera	Certification:	4 Homicide determine	28e. Place of Inju- building, etc		irm, street, fa	ctory, office		2	City or Tou			er or Hurai	Route Number,	
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		(Check only 2 Medical Ex	Physician: To the best of saminer: On the basis of	examination ar	e, death occu nd/or investiga	red at the tir	me, date an	nd place, a	nd due to the	cause(s) date and	and mai	nner as sta	ated. the cause(s)	
	thin 2 the 1 the 2 mplet	Medical	29b. Signature and little of certifier	and manner sta	Ned.		29c. Licens	se number			29d. Date	e signed	d (Month, E	Day, Year)	
)	¥ ¥ 500		> X Sels	ouil, a	40		01	983	38		8/2	21/	201	5	
			30. Name and address of person wh		eath (Item 23a)	(Txpo, Print)	atr	Ril	. /	Juna	PC	olis.	lle	d.	
	St	ate	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature			100		_	1.				
	Regist	rar	AUG 2 4	2005	man b	Ana	AR D								

ORIGINAL

		1 - For State Registrar	State of Maryland /	Depa <i>Cer</i>	irtment of H tificate of I	lealth and M Death	ental Hygi	ene 2 (005	29602	
Physici		1. Decedent's Name (First, Middle, Last)	DORIS WILHID	E H	ARNER		2. Date of Death Month September	Day	Year 2005	3. Time of Death 12:47 P M	
/Medio Examin		4a. Facility Name (If not institution, give standard Arms	reet and number)		4b. City, Town, or Taneyto	Location of Death	-	4c. County			
Funeral Director		5. Social Security Number 6. Sex 171-24-7485	7. Age (In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 30,	_{Үөаг)} 1927	9. Birthp Cour Mary		
Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Carroll C	County Taney						1	0d. Inside City Limits 1 ☐ Yes 2 No	
3a or 28a	i Director	10e. Street and Number 5518 Taneytown Pik	ie		10f. Zip Code 21787			g. Citizen of S		•	
ING Z1Z13-UU30 be filed within 72 hours after death with the Maryland tal Hygiene. d other then *natural', or Itams 23a or 28a-1 show event, the Medical Examinar must be indiffied at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of Hi f Yes, specify Cuba □ Yes 2 No	ispanic Origin? (Spe in, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	Bla	ce - Americ ck, White, y: Whi	etc.	
VITID-UU36 within 72 hours affene. then "natural, or the Medical Exam	Completed	15. Decedent's Educ: (Specify only highest grade Elementary/Secondary (0-12)	ation 16. College (1-4or 5+) 2		lent's Usual Occupa kind of work done o DO NOT use retired Lemaker	ation during most of workir 1)	ng 1	6b. Kind of B		dustry	
aryland 2 should be filed v nd Mental Hygie smarked other umatic event, th	Be	17. Father's Name (First, Middle, Last) Lloyd B. Wilhide					ne (First, Middle, Maiden Surname)				
aryica should and Mei	70	19a. Informant's Name/Relationship (Type	e, Print) 19	b. Mailin	g Address (Street a	and Number or Rura	Ritter I Route Number,	City or Town,	, State, Zip	Code)	
s, Mar and 2 sh lealth and m 27 Is m		Brenda Stonesifer /			1000	vill Drive	-	ytown,			
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ea		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State		sition (Name of natory or other place View Ceme	DCP	. 6	oc. Location arney,	-		
Balt permit. Departi Import any Inj once.		21. Signature of Funeral Service Licensee	Luris		. Name and Addres 36 East B	ss of Facility Sk: altimore S	iles Fun Street	eral H Taneyt		Md. 21787	
Pnysician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. Do	Can	·	g, such as cardiac o		st,		Approximate Interval Between Onset and Death IMONTH	
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icate be executed physician and sthe burial-transit	Examin	Sequentially list conditions, it any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	e of):							
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ecords, P.O. BOX 6 Taw requires that the death certificate been signed by the attending of should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown	c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)		***		ite of delive onth	Day Year	
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The The sage	Completed						24a. Was an autopsy perform	ed?	prior to cor death?	psy findings available npletion of cause of	
VITAL I	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:		Othe	26. Place of Death				assisted	
Division of Vital Records, To the Hospital or Attending Physicien: The law requires t within 24 hours after death. To the Funerel Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be	ertification: To	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	1 ☐ Inpatient 2 ☐ ER/C 28a. Date of Injury (Month, Day Year) 28b	Time of Injury	28c. Injury Work	4 LI Nuising Hon	ne 5 Resider 28d. Describe how			facility	
DIVIS	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	eet, factory, office	2	28f. Location (Stre City or Town,		er or Rura	l Route Number,	
he Hospit n 24 hour he Funer oletely fill	Medical	29a. Certifier (Check only one) Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifier Ph	cian: To the best of my knowled er: On the basis of examination a and manner stated.	ge, death and/or inv	n occurred at the time vestigation, in my op	ne, date and place, a pinion, death occurre	and due to the cau ad at the time, dat	use(s) and ma te and place,	anner as st and due to	ated. the cause(s)	
To t withi To tl	Σ	29b. Signature and title of certifier Well	MO		29c. License	52035	5	d. Date signe	2	2005	
10		30. Name and address of person who con	npleted cause of death (Item 23a 29j 5 toney) (Type,	Print) Penue	Westn	ninis tea	N	1021	157	
Sta Regist	ate rar	31. Date filed (Month, Day, Year) SEP 0 9 2005	29 Stoney 82. Registrar's Signature	Sya	Es.						

State of Maryland / Department of Health and Mental Hygiene 2005 29603 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 1325 M 24 Calvin Emerson Howard AUGUST 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Easton Taibot HOSPITAL ALT EOSTON Memoria If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F Yrs. August 11,1934 Maryland Director 214-30-8883 Usual Residence of Decedent 10c. City, Town or Location 10a State 10h Counts 10d. Inside City Limits "natural", or Itams 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Maryland Dorchester Directo Hurlock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 413 South Main Street 21643 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No 1952— If Yes, Give Year or Dates: 1975 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2X No Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done du life. DO NOT use retired) during most of working Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Jet Engine Technician US Air Force 10 Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should ba Health and Mental Jerome Howard Mildred Stranaghan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) parmit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once. 413 South Main Street, Hurlock, Maryland 21643 Maude Howard/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) Crematory of Delmarva 18/25/2005 Delmar, Delaware 21. Signature of Juneral Se Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631 3a. Part1. Enter the disease, of shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Superior **Physician** Vena 4 Days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Non Small Cell LUNG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine requires that the death certificate be axecuted use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Dunknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause ol death? 2 No 1 TYes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Propatient 2 ER/Outpatient 3 DOA 1 Yes 2 ₩6 this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funeral D 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier N53253 8-24-2005 who completed cause of death (Item/23a) (Type, Print) 30. Name and address of person TIMOTHY SNIEZEK MD 136 LEDNUM Preston, MD 32. Registrar's Signature 31. Date liled (Month, Day, State 2005 020000 Registrar

			Please	Type or Pri	nt in Black In	delible lnk.	Ensure All	Copie	s Are	Legible.	
		•	For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of H rtificate of I		ental H	ygien Reg. No	000	29604
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	Examin	er	4a. Facility Name (If not institution, give				r Location of Death			. County of Deat	
			Frederick Memor 5. Social Security Number 6.5		cal ge (In yrs. last birthday	Frederic		8. Date of B		rederic	
	Funeral Director			I M STRE	56 Yrs.	Months Days	Hours Min.	(Month, D	ay, Year,	1939 Gu	hplace (State or Foreign untry) atemala
	aryland show	2	10a. State 10b. County		10c. City, Town or L		Montufar		Amat	es	10d. Inside City Limits
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	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23e or 28e-f show other traumatic event, the Marical Examiner must be natified at	rai Dir	Toe. Street and Number						Guat	emala	unity :
	or dez	by Funerai	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spec an, Mexican, Puerto R	ify Yes or Nican, etc.)	lo-	14. Race - Ame Black, White	
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Ş	ture!	edt	15. Decedent's E		16a. Dece	dent's Usual Occup	ation		16b. H	(ind of Business/	Industry
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Maryland	2 sho and Is ma		19a. Informant's Name/Relationship			-	and Number or Rural				
	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other tra once.		Sandra Mirando -	daugnter	20b. Place of Disp		et, Frede				1702
Baltimore,	Pages 1 nent of 1- nnt: If ite ury or ot		20a. Method of Disposition 1 Burial 2 Cremation 3		cemetery, cre	matory or other place. Cemetery	(8)			Amates	Izaba1
Ë	it. Pa rtmer rtent njury		*4 □ Donation 5 □ Other (Speci				9-9-20			temala	
Ba	permit. Departr Importe any inju		21. Signature of Fulleral Service 200	n			ss of Facility Stat				e cyland 21702
		-	23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cause one cause on each I	the death. Do not en		The state of the s		-	ick, Mai	Approximate Interval Between
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	/Medical		resulting in death)	a	a consequence of);						1
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×	certif Iding Ise a	Physician/Medica	IF FEMALE:	23c. If yes, outcome	of pregnancy					23d. Date of deli	VPO/
Вох	death le atter ed for u	ciar	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)				Month	Day Year
P.O.	that the de led by the a detached f	ıysi	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unknown							
	res that signed to be deta	by Pi	Part II. Other significant conditions	contributing to death t	out not resulting in the t	ınderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
rds	w require been sig should b	o p						1 🗆	Yes 2	XNo 3□Pri	obably 4 Unknown
Records,	law requires that the as been signed by th 2 should be detache	Completed						24a. Wa	s an	24b. Were au	topsy findings available
R	0 <u>c</u> 0	mo							opsy formed?	death?	ompletion of cause of
Vital	ilcian: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of Death		one)	10163	20010
Į >	Physician: this certific ral director,	ToB	examiner? 1X Yes 2 □ No	Hospital: 1 ☐ Inpati	ent 2 ER/Outpatie	nt 3 DOA Oth				6 □Other (Spec	nify)
Jo u			27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Da	ury 28b. Time o	of 28c. Injun Worl	y at 28	d. Describe	how inju	ry occurred	
<u>Ö</u>	Attending r death. ector: Afte by the fune	atio	2 ☐ Accident investigation	n		M 1 🗆	Yes 2 □No				
Division	l or Attendate after deatl	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of in	jury - At home, farm, st tc. <i>(Specify)</i>	reet, factory, office	28	If. Location City or To	(Street ar	nd Number or Ru e)	ral Route Number,
	urs af irel D										
	Hospitel 24 hours a Funerel riely filled	Medical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	niner: On the basis of	of my knowledge, dear of examination and/or in	th occurred at the tin evestigation, in my o	ne, date and place, ar pinion, death occurred	id due to the at the time	e cause(s , date an) and manner as d place, and due	stated. to the cause(s)
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Mec	29b. Signature and title of certifier	and manner st	Aleu.	29c. License	e number	-	29d. Da	ite signed (Month	ı, Day, Year)
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State Registrar

31. Date filed (Month, Day, Year)

AUG 2 9 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alan Rohrer, M.D. 15 West 7th Street, Frederick, Maryland

37197

21701

8-26-2005

State of Maryland / Department of Health and Mental Hygien 2005 29605 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 28 LOIS WHITELOCK INSLEY 08 0155 05 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Pacility Name (If not institution, give street and number) **Examiner** Keninsula Kegional Medicas Center Jalisburg Wicornice If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day,) May 20, 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🔀 F Yrs. 78 1927 Maryland Director 215 26 5853 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show 1 XYes 2 □ No Director Pittsville Maryland Wicomico 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7570 Maple Street U.S.A 21850 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes. 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 215-0036 1 ☐ Yes 2 XNo Specify: Specify: 3√ Widowed 4 □ Divorced þ White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than College (1-4or 5+) Elementary/Secondary (0-12) 12 Housewife Homemaker or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental is marked o Lora Clayton Elizabeth Pearl Whitelock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Taylor Costanzo Berlin, MD Department of Health Important: If item 27 6 Crow's Nest Lane Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
'4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem, 8/28/05 Frankford, DE 21. Signature of Fureral Service Licensee 22. Name and Address of Facility 108 William St. any Burbage Funeral Home Berlin, MD 21811 23a. Part1. Enjoy the disease, or complications that shock, or heart failure. List only one cause on caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-tran and Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending IF FEMALE nse 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day for 4 Pregnant at time of death 5 Other (specify) ed by the detached Ö 9 Unknown 9 Unknown ن Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 No 1 ☐ Yes 2 ☐ No 1 Yes Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA ٢ 1 ☐ Yes 2 ☐ No o 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After Division 1. Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death 2 Accident completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Die 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Dav. Year) 29b. Signature and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nado m.1)-Δ 31. Date filed (Month, Day, Year) AUG 2 9 32. Redistrar's Signature State 2005 Registrar

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_			Registrar Certificate of Death))		
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A 3	Examin	er.	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location	on of Death		4c. County of			
ē.			15301 Spring Meadows Drive Darnestown 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	der 24 Hrs. 8, [Date of Birth	Montgon		ce (State or	Foreign
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	how how		10a. State 10b. County 10c. City, Town or Location				10	d. Inside Cit	
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Maryland 21215-0036	2 sho and ls ma eume		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number)						
	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. itam 27 is markad other than "natural", or items 23c or 28e-f show other treumetic evant, the Medical Examinar must be notified at		Michael K. Johns / Husband 15301 Spring Mead						.0874
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Baltimore,	then then then then then then then then	-	'4 Donation 5 Other (Specify) Gate of Heaven Cem.	2005		ilver Sp			yland
Ba	permit. Pages 1 and 2 Department of Health a Importent: If itam 27 I. any injury or other tre		21. O atus of Funeral Service Licensee 22. Name and Address of Fact 5130 Wisconsin						016
			23a. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line.	as cardiac or res	piratory arres	st,	1	Approximate nterval Betw Onset and D	veen
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	tal or rs afte el Dii	Certification;	During, vic. (Specify)						
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•	1/3		30, Name and address of person who completed caus of death (Item 23a) (Type, Print)	0131	1	18.0)	
	19		Rosalyn Stewart, M.D. 601 N. Caroline Street, Su:	ite 71/1	3 Ral+	imore. N	m. a	1287	
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State of Maryland / Department of Health and Mental Hygiene 2005 29607 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2005 Knott Sept. 2, 1 20 p M Agnes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Nursing Center Leonardtown St. Mary's 8. Date of Birth (Month, Day, Year)

Oct. 19, 1928 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□M 2√7F Min. 215-20-2851 76 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examinar must be notified at 17 Yes 2 □ No Completed by Funeral Director MD Mary's St. Leonardtown 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? ō 21585 Peabody Street 20650 U.S.A. items 23e 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 ₩ Widowed 4 Divorced "neturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ent: If item 27 Is marked other then ' ury or other traumatic event, the Ms. Elementary/Secondary (0-12) College (1-4or 5+) Farmer Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19. Mailing Moders sy Street and Hymney brown a Proute flumber, and Tokno State dip Code) Julie Van Orden/Guardian P.O. Box 653 Leonardtown, MD 20650 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 09-04-05 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department o Importent: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Crematory Charlotte Hall, MD M00817 22 Arenari Echols Funeral Home, 21. Signature of Funeral Service License P.O. Box 567 La Plata, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a con-**Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons unce of) Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Box 68760, attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but no resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Jivision of Vital Records, 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 TYes filled in by the fur eral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 A Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 2 🗗 No 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred e Funerel Director: After 5 Pending investigation 1 Natural 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated within 2 To the 29b. Signature and title of dentifier 29c. License number 29d. Date signed (Month, Day, Year) f death (Item 231) (Type P 24035 Three Notch Rd. Hollywood, MD 20636 James ∐arboe,M.⊉ 31. Date filed (Month, Da 32 Registrar's Signature State Registrar 2005 DHMH 17 Rev 1/2001

		1	For State Registrar		f Marylan	d / Depa		t of H	ealth a		ental Hy		2006	29608
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	mine	r	5. Social Security Number 6. S	CE AT	THE L 7. Age (In yrs. I	AKE	S If Under	A 4: 1 Year	Location o	CY	MD 8. Date of Bi			th (CO) thplace (State or Foreign buntry)
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death with the Maryland ims 23a or 28a-f show		.	10a. State 10b. County Maryland Wicomico		Delm	y, Town or Lo lar	ocation							10d. Inside City Limits 1X Yes 2 □ No
with the	i	בֿ	10e. Street and Number 812 East State St	reet			10f. Zip					10g. Cit	tizen of What Co Korea	ountry?
		by Fur	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Dec Armed Fo 1 Yes If Yes, Gir Year or D	2 ሺ∐ No ve		Was Deced If Yes, spec		ispanic Origin, Mexican Specify:	gin? (Spe , Puerto I	cify Yes or N Rican, etc.)	0-	14. Race - Ame Black, Whi Specify:	
1215-0 within 72 ho ane. then "natur.		Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation de <i>completed)</i> College (1-4or 5+)	16a. Dece (Give life. Homen	dent's Usua kind of wor DO NOT us	al Occupa rk done d se retired	ation during most ()	of working	ng		and of Business	
Maryland 21215-0036 C d 2 should be filed within 72 hours after th and Mental Hygiene." natural; or lie trannatic event. The Model Expire		To Be Co	17. Father's Name (First, Middle, Last) Unknown			110111011				r's Name	(First, Middle	1		
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Balti permit. Departm Importe	once.		21. Signature of Funeral Service Licen	1800	elle	Z ² 6	Name and Eller 212 01	Fune	ss of Facilit eral l cean (Home,	P.O. Road,	Box Sali	3171 isbury,	MD 21802
Physici			23a. Part1. Enter the disease, or com Shock, or heart failure. List only Immediate Cause (Final	olications that of	caused the death	h. Do not en	ter the mod	le of dyin	,	cardiac o		arrest,		Approximate Interval 8 etween Onset and Death
/Medic Examin	cal		disease or condition resulting in death)		(or as a conseq	uence of):	0/011		Ca	Y CL				ore years
760, te be executed ysician and	100000000000000000000000000000000000000	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	(or as a conseq									
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cords, P. w requires that been signed by	B	ρ	Part II. Other significant conditions	contributing to d	leath but not res	ulting in the u	underlying o	ause give	en in Part I.			tobacco	×	o the cause of death?
	V P	Completed									24a. Wa auto per 1 🗆 Yes	opsy formed?	prior to	utopsy findings available completion of cause of
	DISACTOR IN	To Be	25. Was case referred to medical examiner 1 Yes No	Hospital:	Inpatient 2□	ER/Outpatie			er: 4 🗆 Nu	ırsing Hoı		sidence	6 □Other (Spe	ecify)
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Division let or Attending s after death. al Director: Attended	n da un pa	Certification:	3 Suicide 6 Could not be determined	28e. Flat	e of Injury - At hi ling, etc. (Specil	ome, farm, st	reet, factor	y, office				(Street a. own, State		ural Route Number,
Division (To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: Attending in burden the funeral precions of the funeral precions of the funeral precipe	pletely filt	edicai	29a. Certifier (Check only one) Certifying Plant Certifying Certi	miner: On the i			nvestigation	n, in my o	pinion, dea			, date an	d place, and du	e to the cause(s)
Tot withi Tot	Ego	Z	29b Signature and title of certifier	2/		, no	1	c. Licens	267	278	7		ate signed (Mon	
			30. Name and address of person who	completed cau	COASTA	n 23a) (Type 2 <i>Hos</i>	Print)	R	BO	x/7.	33 8	Solis	il m	05
Reg	Stat gistra		31. Date filed (Month, Day, Year) AUG 2	5 2005	Registrar's Signa	ature	Sam	es.					0,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item 4c per fh 9847 9-12-05 vt
State of Maryland / Department of Health and Mental Hygiene 0 0 5 For State Registrar 29609 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** Eugenia Long September 2005 02:32 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ISaltimore City
If Under 1 Year If Under 24 Hrs. 8. The Johns HUPKINS Hospital Country 8. Date of Birth (Month, Day, May 21 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 € F 88 220-03-7950 Yrs. Director 1917 West Virginia Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 Is marked other than "neturel", or Items 23e or 28e-1 show treumatic event, the M. Jig. ExtraTreat the notified at MD Baltimore Baltimore 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1121 Newcomb Way 21205 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No ģ Specify:White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) House Wife Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 Is marked oth any injury or other treumatic event, 90ce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wayne B. Lipscomb Hazel M. (Morris) Lipscomb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1118 Newcomb Way, Baltimore, MD Lawrence Long Son 21205 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20a. Method of Disposition 20c. Location - City or Town, State Mount Herman 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sept 7 2005 Cumberland, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Faneral Service Licenses 22. Name and Address of Facility Hafer Funeral Service, ad A 1302 National Hwy., LaVale, MD 21502 23a. Part 1. Enter in: disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cluse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Urosepsis 6 day S /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2**X**No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? Yes 2 2 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 🔀 No this 28a. Date of Injury (Month, Day Year) the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide within 24 hours a To the Funerel D 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 3, 2005 dull Res-000 MEDICAL DOCTOR

Registrar
DHMH 17 Rev 1/2001

State

Jane Schell

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Hopkins

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Johns

The

2

Baltimore

Hospital, 600 North Wolfe Street Maryland 21287

Calvin Roger Lee Sr 05-05782 NJM

	702		For State Registrar	State of M	Maryland / De	epartment of Certificate of		nd Mental	Hygier	/	29610					
			Decedent's Name (First, Middle,	Last)				2. Date Mon	of Death		3. Time of Death					
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	Examir	_	4a. Facility Name (If not institution, g	give street and number	er)	4b. City, Town,	or Location of	Death		4c. County of Deat	h					
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	Funeral			5. Sex 7 1 ⊠ M 2 □ F	Age (In yrs. last birtho	Months Davs			of Birth th, Day, Yea		hplace (State or Foreign buntry)					
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Baltimore,	tant:		4 □ Donation 5 □ Other (Spe	primant's Name/Relationship (Type, Print) La Lee/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8213 Morning Dew Lane, Frederick, MD 21702 10b. Place of Disposition (Name of camelery, crematory or other place) 10c. Location - City or Town, State 10c. Location - City or Town, State												
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			23a. Par 1. Enter the disease, or co shock or heart failure. List or	omplications that causely one cause on each	sed the death. Do not	enter the mode of dy	ying, such as c	ardiac or respira	tory arrest,		Approximate Interval Between					
V	Physician	M	Immediate Cause (Final disease or condition	mediate Cause (Final page or condition MULTIPLE TAJUME)												
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Box	eath certific attending pl I for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. tf yes, outcom	me of pregnancy 2 Petal death	2 DEstanta programa				23d. Date of del	ivery					
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Ö	effer effer Dire d in b	Certification:	4 Homicide	building,	etc. (Specify)	DWAY		RU	Or Town, Sta	16) 9/00	LIBERTY					
	To the Hospital or Attending Physicien: within 24 hours effer death. To the Funeral Director: Affer this certific completely filled in by the funeral director.	Medical (est of my knowledge, or s of examination and/o											
	o the	Me	29b. Signature and title of certifier	///		29c. Licer	nse number		29d. [Date signed (Monte	h, Dey, Year)					
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11	+IVA		30. Name and address of person y	no completed cause of	of death (Item 23a) (Ty	pe, Print)				20000, 20	, 2007					
10			31. Date filed (Month, Day, Year).	32. Regi	Sno estrar's Signature		enn Str	eet Ba	1timor	ce, Maryl	and 21201					
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State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 41301 200 Liberto 08 oseph /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Annapolis

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months | Days | Hours | Min. | Aug • 22 • 19 Heritage Harbour Health & Rehab. Anne Arundel Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 XM 2 □ F 1923 Mary land 217-12-5598 81 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location *how 10a, State 10b. County if Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23s or 28s-f show other traumatic event, it is Medical Examinar must be notified at 1 Yes 2 No Director MD Anne Arundel Annapolis 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21403 660 Americana Drive, APt. 48 USA death Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No White If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Manager Food Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 8 Salvatore Liberto Grace Serio ဂ Peges 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 660 Americana Dr., Apt. 48, Annapolis, MD 21403 Della Liberto (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Peges 1 Department of H Importent: If Ite eny injury or ot 1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify) Entembrent Hillcrest Cemetery 8-22-2005 Annapolis, MD 21. Signature of Funeral Pervice Licensee 22. Name and Address of Facility
Hardesty Funeral Home, P.A. Cy 12 Ridgely Avenue, Annapolis, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final hou Gehri **Physician** many 40 resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The taw requires that the death certiticate be executed burial-transit that initiated events resulting in death) Last Due to (pr as a contenuence P.O. Box 68760, physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy ō Month Day Year 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 ☐ Probably 4 XUnknown 2 🗆 No 1 Tes Deen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate 1 ☐ Yes 2 or Attending Physician: uneral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 1 Yes 2 No Certification; To Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Atter 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation М death. atter death Director: in by the i 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide within 24 hours a To the Hospital completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 120 10-3 18 4051 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Centr Croflon M. NOSEINED 31. Date filed (Mont) 32. Regitrar's Signature AUG 2 State 4 2005 Registrar

	1	For State Registrar	State of Maryland	Depa		lealth and	Mental Hy	giene	1.05	29612
Physicia /Medica Examine	n ii	1. Decedent's Name (First, Middle, Last) Kathleen En La. Facility Name (If not institution, give s Memorial Hospital	nma Lear		4b. City, Town, or Cumberl		2. Date of De Month		Year S of Death	3. Time of Death
Funeral Director		5. Social Security Number 6. Sex 220-07-6667	M 2 Q F 83	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Min				ce (State or Foreign
a-f show		Usual Residence of Decedent 10a. State 10b. County MD Allegany	10c. City, To		cation perland				10d	d. Inside City Limits
h with the	Funeral Director	10e. Street and Number 719 Hilltop Drive			10f. Zip Code	21502		10g. Citizen of W		/?
paritificities, Mary facing 2.12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Exprising manual terminist and once.	d by Funer	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No if Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 Yes 2 No	Specify:	(Specify Yes or No erto Rican, etc.)		- American k, White, etc white	C.
vithin 72 t ne. han "nate	Completed by	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	Completed)	(Give life.	nent's Usual Occup kind of work done o DO NOT use retired	ation during most of w d)		own hom		stry
be filed watal Hygie od other t	Be	17. Father's Name (First, Middle, Last) Louis W. Kienhof		AHEH	iakei		ame (First, Middle a M. Frey	, Maiden Sumame	3)	
2 should and Mer is marker raumatic	္ .	19a. Informant's Name/Relationship (Ty Kathy Cunningham			ng Address (Street) Bedford	and Number or	Rural Route Numb		State, Zip C	²⁰ 21502
ages 1 and nt of Healt t; if itam 27	-	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	20b. Place	e of Dispo	esition (Name of matory or other place norial Park	1	Date 9/5/2005	20c. Location - C		n, State
permit. Pages Department of important: if it any injury or once.		. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens:	Almi	22	2. Name and Address Scarpell 108 Virg	inia Aveni	ie: Cumbei	rland MD 2	1502	Approximate
Physician /Medical		23a. Par1. Inter the disease, or complifice, in heart failure. List only or immediate cause (Final disease or condition resulting in death)	ation that caused the death. It to cause on each line. HIP FRACTU Due to (or as a consequent	IRE W				irrest,	lr C	nterval Between Onset and Death DAYS
e be executed /sicien and e burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Unide lying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent	ce of):						
	Physician/Medical	IS SEMALE.	d	ath 3	□Ectopic pregnanc; □ Other (specify) _	у	Cau	1	of delivery	22005 Day Year
w requires that been signed be should be deta	by	Part II. Other significant conditions co	ntributing to death but not resultin	ng in the u	nderlying cause giv	ven in Part I.		tobacco use contri Yes 2 □ No		cause of death?
I Ke The lav ate hes page 2	Completed						24a. Was auto perfe 1 Pes	psy pormed? d	rior to comp eath?	sy findings available pletion of cause of
OT VITS Physicien this certifical director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	28a. Date of Injury 28	b. Time o	III 3LI DOA	ner: 4 ☐ Nursing	Death (Check only g Home 5 Res 28d. Describe	idence 6 □Othe		
DIVISION CONTROLL OF Attending F 24 hours after death. 2	Certification;	1 □ Natural 2 □ Accident 3 □ Suicide 4 □ Homicide 1 □ Natural 5 □ Pending investigation 6 □ Could not be determined	(Month, Day Year) 8/27/2005 28e. Place of Injury - At home building, etc. (Specify) RESIDEN		M 1 🗆	rk? Yes 2X⊡No	28f. Location City or To	TIENT FELL AT HOME cation (Street and Number or Rural Route Number, y or Town, State) HILLTOP DR., CUMB., MD		
Lothe Hospital within 24 hours a To the Funeral I completely filled	Medical (29a. Certifier 1 Certifying Phy (Check only one) 2 Medicel Exami	sician: To the best of my knowle ner: On the basis of examination and manner stated.	dge, deat and/or in	th occurred at the tinvestigation, in my o	me, date and pla opinion, death or	ace, and due to the courred at the time	cause(s) and man , date and place, a	nner as stat and due to t	ted. he cause(s)
To the within 2 To the complete	Mé	29b. Signature and title of certifier	D. Car u	0.	29c. Licens D379			29d. Date signed	I (Month, Di スース(
6		30. Name and address of person who c	O, 940 SETON DE	RIVE,	CUMBERLA	AND, MD	21502			
Sta Registr		31. Date filed (Month, Day, Year) SEP 0 9 200	32 Registrar's Signatur	S.	vie					

			1 - For State Registrar	State of Ma		partment of Heartificate of i		nd Mental Hy	/giene, Reg. No.	2005	29613	
	° Physici	an	1. Decedent's Name (First, Middle, Last,					2. Date of D Month	eath Day	Year	3. Time of Death	
	/Medic			larek		# Ch T		Septent				
	Examin	er	4a, Facility Name (If not institution, give	, 11	àA a	4b. City, Town, or			46. (County of Death	La	
	-		5. Social Security Number 6. Se	4	(In yrs. last birthda	y) If Under 1 Year)とし(() If Under 24	Hrs. 8. Date of B	irth	9. Birth	place (State or Foreign	
	Funeral Director			TM OFFE	87 Yrs.	Months Days	Hours	Min. (Month, D June 8	ay, Year) 3, 191	Cou	aware	
	P.		Usual Residence of Decedent		10. On T						dod Inside City Limite	
	show	_	10a. State 10b. County MD Harford		10c. City, Town or Edgewood						10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	Ne M	ecto	10e. Street and Number			10f. Zip Code			10a Citiz	zen of What Cou		
	with	Dir	714 Clover Vall	ev Ct.		1.0	1040		-	.S.A.		
	Jeath Ins 23	Funerai Director	11. Marital Status	12. Was Decedent E	ver in U.S.	B. Was Decedent of H If Yes, specify Cuba		? (Specify Yes or N	0- 1	4. Race - Amer		
9	within 72 hours after death with the Maryland ene. than 'natural', or itams 23e or 28e-1 show he Madical Erami et mast be nutified at	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2 ☑ No	in, Mexican, F Specify:	-uerto Hican, etc.)		Black, White		
Maryland 21215-0036	ural',	Completed by	3 ☐ Widowed 4 ☐ Pivorced	Year or Dates:						Specify: Wh		
5	"natu	iete	15. Decedent's Edu (Specify only highest grad		(Ĝi	cedent's Usual Occup ve kind of work done o . DO NOT use retired	durina most o	f working	16b. Kin	nd of Business/I	ndustry	
12	withir ene. than	m	Elementary/Secondary (0-12)	College (1-4or 5+	-)	nding	,,		Bool	k Bindir	na	
0	filed Hygi othar ant, I	C	17. Father's Name (First, Middle, Last)		1 211	laring	18. Mother's	Name (First, Middle				
lan.	uld be fental rked tic av	To Be	John Kramarczyk				Mary	y Cwlik				
ary	shot and A sma		19a. Informant's Name/Relationship (T)	pe, Print)	19b. Ma	iling Address (Street	and Number	or Rural Route Numi	ber, City or	Town, State, Zi	p Code)	
Σ,	and 2 ealth n 27		Tom J. Marek (Sor	1)		Clover Va	alley (ewood,		040	
altimore,	ges 1 t of H or oth		20a. Method of Disposition Label Burial 2 Cremation 3 DF	lemoval from State	cemetery, c	position (Name of rematory or other place	1 2/	/9/05		cation - City or T con, Mar		
Ë	t. Pa tmen tant: ijury		` 4 ☐ Donation 5 ☐ Other (Specify)	- 44		te Concept					-y tana	
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygene. Important: if itam 27 is marked other than "natural", or itams 23a or 28a-1 show any njurry or other traumatic avant. The Madical Eramit at must be notified at ODGs.		21. Signature of Funeral Service Licens	Zolln	nan	Tarring—(Cargo H	Funeral Ho Land 2100	ome, I	P.A.		
			23a. Part1. Enter the disease, or comb shock, or heart failure. List only o	ications that caused to	the death. Do not e	enter the mode of dyin	g, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition			NEME II	-14				Onset and Death	
	/Medical		resulting in death)	Due to (or as a	consequence of):	DEMEN	.,,,					
	Examiner		Sequentially list conditions,	Due to for so o	acceptance of							
	ed isit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):							
/ 	xecut and al-trar	xan	that initiated events resulting in death) Last	Due to (or as a	consequence of):							
8760,	death certificate be executed e attending physician and d for use as the burial-transit		l	1								
9	tificat ig phy as thi	ledi	=									
Вох	death certifica attending ph d for use as t	an/N	23b. was decedent pregnant	3c. If yes, outcome o		B Ectopic pregnancy	,		2	3d. Date of deliv		
O. B	ne dea the att	Physician/Medical	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at t 9☐ Unknown		Other (specify)				IJITIOIN	Day Year	
<u>Ч</u>	t t		Part II. Other significant conditions co	ntributing to death but	t not resulting in the	underlying cause giv	en in Part I.	23e. Did	tobacco us	se contribute to	the cause of death?	
ds,	signed d be del	d by	CORONARY AK		SEASE			1 🗆	Yes 2	No 3□Pro	bably 4 Unknown	
Sor	law requires as been sign 2 should be	iete						24a. Wa	s an	24b. Were aut	opsy findings available	
Vital Records,	0 4 9	Completed							ormed?	prior to co death? 1 Yes	ompletion of cause of	
ta	ician: Th	o ·	25. Was case referred to medical				26. Place of	1 ☐ Yes f Death (Check only	2 No one)	10163	20140	
Į <	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 22 No	lospital: 1 Inpatien	t 2 ER/Outpat	ient 3 DOA	er: 4 Nursi	ing Home 5□Res	idence 6	Other (Speci	fy)	
n of	Jing Pt J. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time	Wor		28d. Describe	how injury	occurred		
sio	Attanding r death. actor: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be		211		Yes 2 □No		/C+===+	A Mumbas as Rus	al Route Number,	
Division	l or Attano after death Diractor:	Certification:	4 ☐ Homicide determined	building, etc.	y - At nome, tarm, (Specify)	street, factory, office			own, State)	I NUITIDEL OF MUL	ar mobile Number,	
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	-22		sicien: To the best of								
	in 24 in 24 in Eu pleteil	edic	one)	ner: On the basis of e and manner stat				occurred at the time				
	To t To t	Σ	29b. Signature and title of certifier	1		29c. Licens				signed (Month,		
•			Millia	fren 1	40	04	5349		09,	106/2	2005	
	5		30. Name and address of person wife 9	1	ath (Item 23a) (Typ	e, Print) UON AVE		C N=101	100	1 . 1 . 2	7.6	
	Sta	te	SURESH DHANJA 31. Date filed (Month, Day, Year)	32. Registra	6225.01 r's Signature	U/ON HIVE	HAVA	CR UT GICH	ce	170210	110	
	Regist		SEP 1 2 21		J. J.	Sigete 5						
DH	MH 17 Rev 1/2	001	ULI LACI	JULIEUK	V 10 1							

Marek, Mary L

			For State Registrar	State of	f Marylan	d / Depa <i>Cei</i>	artment of H tificate of I	lealth a <i>Death</i>	ind Me	ental Hyg	giene Reg. No. 2 ()	05	29614
	Physicia	an	Decedent's Name (First, Middle	e, Last)					2	2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic	al	George Ronald 4a. Facility Name (If not institution	McMullan			4b. City, Town, or	r Location of		August	26, 200		10:30 AM
	Examin	er	5954 Watch Chai	_			Columbia				Howar	d	
ı	Funeral Director		5. Social Security Number 254–58–1696	6. Sex 1∭ M 2☐ F	7. Age (In yrs. 64		If Under 1 Year Months Days	If Under 2 Hours	Min.	B. Date of Birt (Month, Day Nov 22	1940	9. Birthp Cour Geor	place (State or Foreign http) gia
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation					1	10d. Inside City Limits
	e-f sh	ctor	Maryland Howard	Ĺ	Co1	umbia							1 ☐ Yes 2 🔼 No
	with th	Funeral Directo	10e. Street and Number	- Uor #11	0.3		10f. Zip Code 21044			1	10g. Citizen of ' USA	What Cou	ntry?
	ns 23e	eral	5954 Watch Chai	12 Was Dece	edent Ever in U	.S. 13. ¹	Was Decedent of Hi f Yes, specify Cuba	ispanic Orig	gin? (Speci				can Indian,
ထ္	within 72 hours after death with the Maryland ene. then "natural", or Items 23a or 28e-f show fre Moucal Examiliar in ust be motified at	Fun	1 Never Married 2 Marr	Armed Fo	rces? 2 No		f Yes, specify Cuba 1 □ Yes 2X No	an, Mexican, Specify:	, Puerto Ri	ican, etc.)	1	ck, White,	
8	ural',	d by	3 ☐ Widowed 4 ☐ Divorced		re ates:1963-	6/						Whit	
21215-0036	in 72 n "nat	Completed	(Specify only highe	t's Education st grade completed)	1.405.51	(Give	dent's Usual Occup: kind of work done o DO NOT use retired	during most d)	of working	7	16b. Kind of B	usinessan	dustry
ณ	d with giene. er tha	Com	Elementary/Secondary (0-12)	College (1 5+		Psych	ologist				Menta1		th
Maryland	should be filed within 72 hours after death with the Marylan nd Mental Hyglene. It marked other than "natural", or Items 23a or 28e-f show unatic event, I're Macagal Ex Instrument be notified at	Be	17. Father's Name (First, Middle, George Pierce M							<i>First, Middl</i> e, ne Hunt	Maiden Suman	ne)	
7	s 1 and 2 should f Health and Mer Item 27 Is marke other traumetic	우	19a. Informant's Name/Relations			19b. Mailie	ng Address (Street a					State, Zip	Code)
Š	d 2 th a 17 Is		Ronald Scott Mo		n		Pine Rea						
ore,	of He		20a. Method of Disposition 1 □ Burial 2X Cremation		State 20b. P		sition (Name of natory or other place		ugusi		20c. Location		
Baltimore,	. Pag tment tant: I		`4 □Donation 5 □ Other (S	Specify)	W.		1 Cremato		2005		Odenton		
Ba	permit. Pages 1 an Depertment of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Service	Health	MO1	251 Be	Name and Address ing Home verly L.	Heckr	otte	. P.A.	Clarks		, MD 21029
I			23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	only one cause on e	ach line.			ig, such as o	cardiac or i	respiratory ar	rest,		Approximate Interval Between Onset and Death
}	Physician /Medical		disease or condition resulting in death)	a. Due to		uence of):						^	(INEMONTHS
	Examiner		Sequentially list conditions	b									
	be sit	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to	(or as a conseq	tienes or):							
	xecution and al-tran	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):						-	
8760,	ate be executed hysician and the burial-transit			d									
9	ing physics in a set the	Physician/Medical	IF FEMALE:										
Вох	death certifics e attending ph ed for use as ti	lan/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	tcome of pregna pirth 2 ☐ Feta nant at time of d	I death 3	Ectopic pregnancy Other (specify)	1			1	te of delive onth	ery Day Year
o.	0 0 0	nyslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unkno		odii 5							
S, D	law requires that the as been signed by th 2 should be detache	by PI	Part II. Other significant conditi	ons contributing to de	eath but not res	ulting in the u	nderlying cause give	en in Part I.		23e. Did to			he cause of death?
ord	v require been si should b									1 🗆 Y		3 Prot	
Records,	The law ate has b bage 2 sl	Completed								24a. Was autop perfor	rmed?	prior to co death?	opsy findings available impletion of cause of
Vital		a)	25. Was case referred to medica	ı				26. Place	of Death (1 ☐ Yes Check only o		1 🗆 Yes	2 L No
of Vi	Physiclan: r this certific ral director,	To B	examiner? 1 🗌 Yes 2💥 No	Hospital: 1 □ I	Inpatient 2	ER/Outpatier		4 U Nur	rsing Home	e 5∏XResid	lence 6 🗆 Oth	ner (Specii	(y)
	ding Pl		27. Manner of Death 1 Natural 5 □ Pendir	ig .	of Injury th, Day Year)	28b. Time o Injury	Worl	yat k? Yes 2 □ N		ld. Describe h	low injury occur	red	
Division	or Attending after death. Director: After in by the fune	ertification;	3 ☐ Suicide 6 ☐ Could	nined 289. Place	of Injury - At he	ome, farm, sti	reet, factory, office	103 2				per or Run	al Route Number,
$\frac{1}{2}$	s after s after N Direction od in by	Certi	4 Homicide	buildi	ing, etc. (Specif	(y)				City or Tow	m, State)		
	To the Hospitel or Attending i within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical (29a. Certifier Check only one) Certifyi	ng Physician: To the Examiner: On the b and man	best of my kno asis of examina ner stated.	wledge, deat tion and/or in	h occurred at the tin vestigation, in my o	ne, date and pinion, deat	d place, an th occurred	d due to the d at the time,	cause(s) and madate and place,	anner as s and due to	stated. o the cause(s)
)	To the within 2 To the complei	Me	29b. Signature and the of pertific	"clist.	mo		29c, Licens	e number 298	88		29d. Date signe August	,	
ok	1)00		30. Name and address of person DAVID LEICE	+TCING	545	OK	NOU N	lo RTH	Dr.				Marinia -
1	Sta Registi		31. Date filed (Month, Day, Year, AUG 2	9 2005 32. 8	Sistrar's Signa	ature	berli						

		•	For State Registrar		Maryland / Dep <i>Ce</i>	artment of H rtificate of I		F	Reg. No.20		29615
	Physici /Medio Examir	al	Decedent's Name (First, Middle SONIA MARIE MO 4a. Facility Name (If not institution	HNEY	per)	4b. City, Town, or	Location of De	2. Date of Dea Month AUGUST	Day 19, 200 4c. County	Year 05	3. Time of Death
	Funeral Director		MILLENNIUM HEA 5. Social Security Number 015 28 8594		BILITATION Age (In yrs. last birthday) 67 Yrs.	EDGEWATE If Under 1 Year Months Days	R If Under 24 H Hours M		ANNE A (, Year) 1, 1937		ce (State or Foreign
	he Maryland 28e-f show offilied at	Director	Usual Residence of Decedent 10a. State 10b. County MARYLAND ANNE 10e. Street and Number	ARUNDEL	10c. City, Town or L				10g. Citizen of W		I. Inside City Limits 1 Yes 2 No
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Iteme 23e or 28e-1 show any Injury or other treumatic event, Ite Medical Exam her must be notified at ONCE.	Funeral	3412 HAZELWOOD 11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	12. Was Deced Armed Force ned 1 Tes 2	es? L X No	21037 Was Decedent of H If Yes, specify Cuba	ispanic Origin? In, Mexican, Pu Specify:	(Specify Yes or No-	UNITED 14. Race Black		TS Indian,
21215-0036	ed within 72 hour rgiene. er then "naturel" i, the Medical Ex	Completed by	15. Deceder (Specify only higher Elementary/Secondary (0-12) 12	st grade completed) College (1-4	16a. Dece (Giv life.	edent's Usual Occup e kind of work done of DO NOT use retired	during most of v		16b. Kind of Bu	siness/Indus	stry
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	Frysician /Medical Examiner		23a. Part 1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a	used the death. Do not er	1973 SOLOM After the mode of dyin	ONS ISI	AND ROAD	EDGEWA	TER, M	21037 Approximate Interval Between Onset and Death
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.O. Box 68	death certifica e attending ph ed for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Mono 9 ☐ Unknown	1 Live bir	nt at time of death 5	□Ectopic pregnancy	1		23d. Date Mor	e of delivery	ay Year
Records, P.	requires een sign	by	Part II. Other significant condit	ons contributing to dea	ath but not resulting in the	underlying cause giv	en in Part I.	23e. Did to	I	3 🗌 Probab	
Vital Rec	Phyelcien: The law this certificate has b ral director, page 2 sl	Be Completed	25. Was case referred to medicional examiner?	Hospital:		Oth	1000	autor perfo 1 Yes	psy rmed? d 2 2 No 1	rior to comp eath? Yes 2	□ No
Division of \	ng Phye Viter this	Certification; To	3 ☐ Suicide 6 ☐ Could	28a. Date of (Month) igation not be 28e. Place of	patient 2 ER/Outpatie Injury (Day Year) 28b. Time Injury Injury of Injury - At home, farm, s g, etc. (Specify)	of 28c. Injur Wor M 1	y at	28d. Describe	dence 6 Other now injury occurre Street and Number n, State)	ed	Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fo	edical	(Check only 2 Medica	Examiner: On the bas and manne	pest of my knowledge, dea sis of examination and/or ar stated.	nvestigation, in my c	pinion, death o	ccurred at the time,	date and place, a	and due to th	he cause(s)
ļ	with 10 Con	W	29b. Signature and title of certifiting and signature and different formation and signature and sign		of death (Item 23a) (Type	29c. Licens		28 Annapo	8 · 22		
	St Regist	ate rar	Aditud Cho 31. Date filed (Month, Day, Yea AUG 2	5 2005 32. Ag	GLOOR A	gely Av	(.#23)	Mnapo	115,m	D.ZI	401

State of Maryland / Department of Health and Mental Hygiene 2005 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) BARBARA ELATNE MURPHY 2. Date of Death 3. Time of Death Month **Physician** SEPT. 4, 2005 6:30 AM BARBARA ELIZABETH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner PRINCE GEORGE'S WASHINGTON ADVENTIST HOSP. PARK TAKOMA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 M XCXF Director 219-76-9700 9,1959 MARYLAND Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Extending in ust be notified at 1 Yes 2 No Director MARYLAND CHARLES NEWBURG 10e. Street and Number 10f. Zip Code 10g. Cilizen of What Country? 20664 U.S.A. 10585 MT. VICTORIA ROAD by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Year or Dates: Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry end Mental Hygiene. Is marked other than College (1-4or 5+) Elementary/Secondary (0-12) 9 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MARTHA ELIZABETH GEORGE HENRY ALVEY, SR. CARGILL 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 end 2 ment of Heelth e ent: if item 27 la 20664 P.O. BOX 254, NEWBURG, WILLIAM L. MURPHY-SPOUSE MARYLAND other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Slate tXDeurial 2 ☐ Cremation 3 ☐ Removal from State ò Department of Importent: if any injury or once. DENTSVILLE UMC CEMETERY 9-8-05 * 4 □ Donation 5 □ Other (Specify) DENTSVILLE, 21. Signature of Fyneral Service Licensee M00479 2. Name and Address of Facility RAYMOND FUNERAL SERVICE P.A. 23a. Part1. Enter the disease, or complications in all sused the death. Do not in er the mole of dying, such as carriac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 30 MINUCO Immediate Cause (Final disease or condition resulling in death) Respiratory A cute Physician tailure /Medical Due to (or as a consequence of): Examiner Heart unknown scheinic Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical use as the attending p for use as IF FEMALE: 23c. If yes, oulcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day 4☐Pregnanl at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed pavoxsymal atrial 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Coronary Disease Artery 24a. Was an page 2 s autopsy performed? End Stage Renal Disease mellitus Diabetes 1 ☐ Yes 2 No neral Director: After this certific filled In by the funeral director. Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 EP/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) Certification: To 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely within 2 To the ro the 29d. Dale signed (Month, Day, Year) 29c. License number 29b. Signature and little of certifier September 4 - 2005 D6100/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kenneth Khandagle, MD 831 & University Blud #25 Vilver Joring, MD 20903 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			1- State of Maryland / Department of Health and Mental Hygiene 20c per FH, C848, 10/12/05dhb Reg. No. 205 296	17
			Decedent's Name (First, Middle, Last) Decedent's Name (First, Middle, Last) Decedent's Name (First, Middle, Last) Decedent's Name (First, Middle, Last) 3. Time of Decedent's Name (First, Middle, Last)	ath
П	Physicia /Medic		21 2005	A ^M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
			508 North Sixth Street Denton Caroline	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fo	sreign
	Director		217-26-5218 77 January 12, 1928 Maryland	
	land ow		10a. State 10b. County 10c. City, Town or Location 10d. Inside City L	imits
	Mary F-f sh	tor	Maryland Caroline Denton	□No
	n 188	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
	238 C	alD	508 North Sixth Street 21629 United States of Ame	rica
	r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.	
36	or H	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give 1 □ Yes 2 □ No Specify: Specify: Caucasian	
21215-0036	72 hours after death with the Maryland 'naturel', or ttems 23e or 28e-f show disal Examinations be rediffed at	ed b	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry	
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	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Madical Examinar must be rediffed at		Deborah Ciolek Daughter 4077 Elmer Drive, Greenood, Delaware 19950	
Baltimore,	Pages 1 nent of H int: If Itel		20a. Method of Disposition 1	
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3al	permit. Page Department of Importent: If any injury or once.		21. Signature of Juneral Service Versee 22. Name and Address of Facility Moore Funeral Home, P.A.	
	402 e d		23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,	2
			shock, or heart failure. List only one cause on each line. Immediate Cause (Final	
	Physician /Medical		disease or condition a 1/33Ca)	Z
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Vital Records,	iician: Th certificate rector, pag	e Co	Chronic Obstructive Vulmonary Diseas 1 Yes 20 No 25. Was case referred to medical 26. Place of Death (Check only one)	
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	To To		1 1 2 1 2 0 WIN 131371 9-1-15	
7			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
	Sta	ite	James Sides, M.D. 920 Market Street, Denton, Maryland 21629 31. Date filed (Month, Day, Year) SEP 1 2005	
	Regist	ar	SEP 1 2005	

State of Maryland / Department of Health and Mental Hygien 200529618 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** WILLIAM JAMES NEFF 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore VA Mourae Center Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 24,1929 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Maryland 1**XX**4 2□ F 220-22-3127 Director 76 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Erans at must be rediffed at 1 ☐ Yes 2 X No Director MD Anne Arundel Gambrills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours aftar death with 609 Neff Drive, P.O. Box 204 21054 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 □ No If Yes, Give Year or Dates: Korea 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Equipment Mechanic Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Menial Hy Important: if Item 27 is marked oth any injury or other traumatic event any injury or other traumatic event angel. Be Alfred Neff Clara Fiori 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Anne Neff (Wife) 609 Neff Dr., P.O. Box 204, Gambrills, MD 21054 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State 8-25-2005 Baldwin Mem. U.M. Cem Millersville, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licenses THOMOOX 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TISSUE FOXIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** VENTRICULAR FIBRILLATION MINUTES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner use as the burial-transit The law requires that the death certificate be executed CARDIOMYOPA YEARS that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, DISEASE Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No has page 2 this certificate Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident completely filled in by the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide ö within 24 hours a To the Funerail 29a, Certifier 1. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOCH ANCECA 0 Ropack 31. Date filed (Month, Day, Year) 32. gistrar's Signature State Registrar

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de la constante de la constant	3a or		2196 Bellemonte Co				217	5.5				USA				
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ָם מ	certificate has sector, page 2	e Co	25. Was case referred to medical						26 Place	of Deat	1 ☐ Yes		1	Yes 2	∐ No	
>	dring Friystetant. The h. After this certificate h. funeral director, page	O B	examiner? 1 ☐ Yes 2 🏋 No	Hospital:	Inpatient 2	ER/Outpatie	nt 3 □ D0	Othe	75		me 5 Re		Other	(Specify)		
5 6	ter this	Ju: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date (Mon	of Injury oth, Day Year)	28b. Time o	of 2	8c. Injun	at c?		28d. Describe	how injury	occurred			
5	eath. or: Al	catle	2 Accident investigation 3 Suicide 6 Could not to				М		Yes 2 🗆	No	006 1	(044	d 81	as Direct	Davida Africa ha	
<u> </u>	or An uffer d Diract in by	Certification:	4 Homicide determined	280. Place	e of Injury · At h ling, etc. (Speci	ome, tarm, st fy)	treet, factor	y, office			28f. Location City or T	own, State		or Hurai i	Houle Numbe	er,
	in the nospital or Attenuing virtin 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 (X Certifying P (Check only 2 ☐ Medicel Exe													
	tha Phin 24 tha F nplete	Medical	one)		ner stated.				e number				signed (
1	To Will	-	29b. Signature and title of certifier	X	_					1.1						
	Ц		30. Name and address of person who Saeed Zai		se of death (Ite		Print)	Hou	se,	AL	e, F	red	eric	k 1	40	
	Sta Registr		21 Date filed (Months-Day, Year)	2005 32.5	gistrar's Sign		liede	7								

		•	For State Registrar		State	of Mary	land / De _l	oartmen e <i>rtificat</i>				ental Hy		2005	296	20
ı	Physici		1. Decedent's Name Marion	(First, Middle, I	,	ite		Pric	:e			2. Date of De Month Augus	Day	Year 2005	3. Time of Dea 7:30 a	
}	/Medic Examin		4a. Facility Name (If I		ive street and i					Location (of Death		4c. C	ounty of Death		
	Funeral		425 Crea 5. Social Security Nur		. Sex		yrs. last birthda	y) If Under	1 Year			8. Date of Bi (Month, Da		ueen Ar	I nes place (State or Fo intry)	reign
	Director		015-26-7		1□M 2 X)F		76 Yrs.	Months	Days	Hours	Min.	Sept.	28,19	28 Mas	sachuset	
	inyland show			10b. County		10	c. City, Town or	Location							10d. Inside City Li	
	the Ma	Director	MD 10e. Street and Numl		Annes		Centr	eville					10g Citize	en of What Cou	1 ☐ Yes 21x	X
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	death	Funeral	11. Marital Status		12. Was D	ecedent Ever Forces?	in U.S.	3. Was Dece			igin? (Spe	cify Yes or No Rican, etc.)		Race - Amer Black, White		
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, The Midical Exartinal must be neilling at ODGs.	þ	1 Never Marrie		1 □Ye If Yes.	s 2XXNo		1 ☐ Yes		Specify:		, , , , , , ,		Specify: Wh		
Maryland 21215-0036	"natural	Completed	(Specif	15. Decedent's y only highest	Education grade complete	nd)	(Gi	cedent's Usu ve kind of wo	rk done i	du <i>rina</i> mos	it of worki	ng	16b. Kind	of Business/l	ndustry	-
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nd	al Hyg	Bec	17. Father's Name (F	First, Middle, La	st)					18. Mothe	er's Name	(First, Middle	, Maiden S	umame)	-	
ryla	d Meni d Meni narke	2	Laurence		(Tyne Print)		19h Ma	iling Address	Street .			te Cro		Town, State, Z	p Code21617	
Ma	nd 2 sl alth and 27 ls r r traur		William			band)									11e, MD	
Baltimore,	of Hez	1	20a. Method of Dispo	osition		2	Ob. Place of Dis		me of	e)	C	ate		ation - City or T		
ţ	rtment rtant: njury o	,	*4 □Donation 5	5 ☐ Other (Spe	city)		Metro C	remato 22. Name ag			8-20-	-2005	Balt	imore,	MD	_
Ba	permi Depa Impo any iu		21. Signature of Puri	eral series Eli	· ·	_		Hard	esty	Fune	eral	Home,	P.A.	MD 21	401	
			23a. Part L Enter the shock, or heart	e disease, or co	omplications that	at caused the	death. Do not								Approximate Interval Between Onset and Deat	
	Physician /Medical		Immediate Cause (F seas or condition r up g in death)	inal	_ a	LU	ng (cano	er						5 year	5
	Examiner			_	Due	to [or as a co	onseque ce of):								,	
	D iii	Iner	Sequentially list condition if any, leading to important the condition of the condition in the condition of the condition in the condition in the condition of the condition in the condition of the condition in	VICE -	b. — Due	to (or as a co	onsequence of):									
-	te be executed ysician and e burial-transit	Examiner	Cause (Disease or in that initiated events resulting in death) La		c	to (or as a co	onsequence of):									
1760,		cal			d											
x 68	leath certificat attending phy I for use as the	/Med	IF FEMALE:		23c If yes	outcome of p	regnancy			-			20	3d. Date of deli	(00)	
O. Box	0 0 0	Physician/Med	23b. Was decedent in the past 12 n 1 \(\supersection \) Yes	nenths?	1□Liv 4□Pri	re birth 2 egnant at time sknown	Fetal death	3 □Ectopic p 5 □ Other (s						Month	Day Year	
α.	that the		9 □ Unknówn N Part II. Other signific	cant condition	s contributing to	o death but no	ot resulting in the	e underlying	cause giv	en in Part	l.	23e. Did	tobacco us	e contribute, o	the cause of death	1?
rds,	·= 00 m	ed by										1 🗆	Yes 2□	No 3 7 ro	babiy 4 🗆 Unkn	own
Record	و کے و	ompleted										24a. Was		prior to c death?	opsy findings avail empletion of cause 2 No	
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of V	hys this	၉	1 Yes	No		☐ Inpatient	2 ☐ ER/Outpat			4 🗆 N	ursing Ho	me 5 Res 28d. Jescribe		Other (Spec	rfy)	
	ding h. After fune	tton	27. Manner of Teath 1 Natural 2 Accident	5 Pending investiga	(N	fonth, Day Ye	ear) Injur	y M	28c. Injur Wor 1 🗌	k? Yes 2□				000011100		
Division	I or Attendii after death. Director: A I in by the fu	ertification:	3 Suicide 4 Homicide	6 Could no determin	Ad 200. PI	ace of Injury uilding, etc. (S	At home, farm, Specify)	street, factor	y, office		Ī		(Street and wn, State)	Number or Ru	al Route Number,	
_	Hospital	edical C	29a. Certifier (Check only one)	Oertifying	kaminer: On th	the best of me basis of examples stated	ny knowledge, de amination and/o	eath occurred investigation	at the tir	ne, date a	nd place, a	and due to the ed at the time	cause(s) a date and p	nd manner as place, and due	stated. to the cause(s)	
	ro the vithin 2 ro the comple	Med	29b. Signature and t	itle of certifier	anon	anner stateo		29	c. Licens	e number			29d. Date	signed (Month	, Day, Year)	
			> fee	nine	Wer	reg.	MD		05	28	30		Ava	gust	19,200	5
			30. Name and addre	ss of person w	ho completed o	ause of death	Gestac	pe, Print)	世3	0	An	ap o	3, 1	NO	21401	
	Sta Regista		31. Date filed (Month		2005	Registrar's		book	,			1				

State of Maryland / Department of Health and Mental Hygiene 2005 29621 Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Month **Physician** Evelyn R. Purdum 22, 2005 4:15p August /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery General Hospital Montgomery Olney If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Months 1 ☐ M 2 🕱 F Yrs. 21 1925 Director 79 Dec. New York 577-38-5032 Usual Residence of Deceden the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or items 23a or 28a-f show the Medical Experimental be notified at 1 ☐ Yes 2 No Directo Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 1305 Magnolia Road 20905 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Yes. Give If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental Is markad Charles Roberts Ethel Foster ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a 1305 Magnolia Road, Silver Spring, Maryland 20905 Roger L. Purdum/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or ^ 4 □ Donation 5 □ Other (Specify) Crownsville Veterans | Cemetery Crownsville, Maryland 22. Name and Address of Facility Olin L. Molesworth P. A. Funeral Home 21. Signature of Funeral Service Licenses 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 🛮 No Division of Vital Records, P.O. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 3 pe 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2X No Hospital or Attanding Physician: 4 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2XNo filled in by tha funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 🛮 Naturai 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature a 29c. License number D00063196 August 22, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Matthew C. McAndrew MD 18101 Prince Philip Drive, Olney, Maryland 20832 32. Registre's Signature 31. Date filed (Month, Day, Year) AUG 2 9 2005 Registrar

			State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Certificate of Death Reg. No. 2005
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year September 5, 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	Funeral Director		St. Catherine's Nursing Center Emmitsburg Frederick County 5. Social Security Number 218-05-2626 6. Sex 1 M 2 KF 7. Age (In yrs. last birthday) 86 Yrs. 1 M 2 KF 86 Yrs. Wonths Days Hours Min. May 13, 1919 Maryland 9. Birthplace (State or Foreign Country) 9. Birthplace (State or Foreign Country) May 13, 1919 Maryland May 13, 1919 May
	e Maryland	ector	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pennsylvania Adams County Littlestown 1 X yes 2 □ No
	h with the	al Dire	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 250 Charles Street 17340 United States
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23s or 28s-f show other traumetic event, the Medical Examinations to collined at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forcas? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lift Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No Specify: White
21215-0036	d within 72 ho giene. or than "natur the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) farmer 16b. Kind of Business/Industry agriculture
Maryland	s should be filed and Mental Hygie Is marked other sumetic event, II	To Be C	17. Father's Name (First, Middle, Last) Charles Frederick Brawner 18. Mother's Name (First, Middle, Maiden Sumame) Mary Julia Carbaugh
	1 and 2 shu Health and iem 27 Is m		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earleen S. Sanders / daughter P.O. Box 429 Emmitsburg, Maryland 21727
Baltimore,	Page tent o nt: If ry or		20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) New St. Joseph's Cem. 20c. Location - City or Town, State Sept. 9 2005 Emmitsburg, Maryland
Bal	permit. Departm Imports any Inju		21. Signature of Funeral Service Licenses 22. Name and Address of Facility Skiles Funeral Home 136 East Baltimore Street Taneytown, Md. 21787
760, <	Provided / Medical Examiner provided prival-transit	cal Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter or Johning Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):
.O. Box 68	that the death certificat led by the attending phy detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
Records, P.	e law requires has been sign je 2 should be	Completed by P	Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1XYes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
Vital B	yslcian: The l is certificate ha director, page	Be Co	25. Was case referred to medical examiner? 26. Place of Death (Check only one)
of	ding Phys h. After this funeral dii	Certification; To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Delith 1 Natural 5 Pending 2 Accident investigation 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Injury 4 Work? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No
Division	il or Attendate after death	ertific	3 Suicide 6 Could not be determined 6 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	Touhe Hospital or Attenwithin 24 hours after deati To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	Touth within To th comp	M	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9 - 5 - 0 5
	H		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan L. Carroll, M.D. 310 South Seton Avenue Emmitsburg, Md. 21727
	Sta Registi		31. Date filed (Month, Day, Year) 32. Relistrar's Signature SEP 1 2 2005

			1 - For State Registrar	ate of Maryla		artment of H			ene 200	5 29623				
			Decedent's Name (First, Middle, Last)					2. Date of Death	g. 110.	3. Time of Death				
	Physici /Medio		WARREN J.	ROWE 3				Month AUGAST	Day Year 20	1 1				
	Examin	er	4a. Facility Name (If not institution, give stree UNIVERSITY OF MAI		edical enter	_	Location of Death		4c. County of De					
	Funeral		5. Social Security Number 6. Sex		rs. last birthday)	Baltmi If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	No Cou					
	Director		220-54-9992 ¹™M	2□F 48	Yrs.	Months Days	Hours Min.	(Month Day)	57	Birthplace (State or Foreign Country) MD				
	and		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits				
	Maryl	tor	MD Worcester		Ocean C					1 XYes 2 No				
	th the or 28e e roll	irec	10e. Street and Number		occun o	10f. Zip Code		10	g. Citizen of What	Country?				
	ath wi	ralD	10425 Brighton Rd.			2184			ISA					
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importents: If item 27 is marked other then "neturel", or Items 23e or 28e-1 show any injury or other treumetic event. The Medical Enarther must be retified at anone.	Completed by Funeral Director	1 Never Married 2 X Married 1	Vas Decedent Ever ii kmed Force <i>s</i> ? □Yes 2 XX No Yes, Give 'ear or Date <i>s</i> :	1	Was Decedent of Hi f Yes, specify Cuba I□Yes 21□No	ispanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, W. Specify: W					
5	"netu	ietec	15. Decedent's Educatio (Specify only highest grade con		16a. Deced (Give	lent's Usual Occupa	ation during most of work: l)	ing 16	b. Kind of Busines	ss/Industry				
7	within ene. then	duic	Elementary/Secondary (0-12)	college (1-4or 5+)		r-Operato		ţ	Home Imp	novement				
קס	e filed Il Hygi other	Be Co	17. Father's Name (First, Middle, Last)		OWITCH	operato	18. Mother's Name			rovement				
ylar	Menta Menta Brked Bric e	To E	Warren James Rowe				Arabelle	King						
Maryland	d 2 sh h and 7 is m treum		19a. Informant's Name/Relationship (Type, I				and Number or Rura							
	Heall tem 2		Patricia Rowe (wife 20a. Method of Disposition	201	p. Place of Dispos	sition (Name of	n Rd., Oc		Md. 218					
Ë	Pages nent of H ent: If ite ury or of		1 ☐ Burial 2 🗡 Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	val from State	· ·	lopen Cre		-2005 F	rankford	. DF				
Baltimore,	permit. Departn Importe any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ullrich Funeral Home 10902 Ocean Gateway, Berlin, Md. 21811											
Т			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one care	ns that caused do duse on each line.	eath Do not ente	er the mode of dying	g, such as cardiac o	or respiratory arres	t,	Approximate interval Between				
	Physician		Immediate Cause (Final disease or condition	Alcoholi	ic civil	losis				Onset and Death				
b	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Alcoholic (IVTHOSES Due to (or as a consequence of): Upper GI bleed											
	- A-													
	cuted nd ransit	Examiner												
8760,	rate be executed physician and the burial-transit	EX I	resulting in death) Last	Due to (or as a cons	sequence of):									
687	ficate I physi s the t	edical	d.											
P.O. Box (ne death certifii the attending p thed for use as	Physician/Me	in the past 12 menths?	yes, outcome of prediction of predictions of the control of the co	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	lelivery Day Year				
	res that the de signed by the a be detached f	by Ph	Part II. Other significant conditions contribu	ting to death but not	resulting in the ur	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute	to the cause of death?				
rds	w require: been sig should b							1 ☐ Yes	2 €No 3 🗆	Probably 4 Unknown				
Division of Vital Records,	The la	Completed						24a. Was an autopsy performe	d? prior to death?	autopsy findings available o completion of cause of ? es 2 \(\) No				
<u> </u>	Physicien: Th this certificate ral director, paç	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospi	tal: 1 Impatient 2	☐ ER/Outpatient	Othe	26. Place of Death		0.5700					
0	g Physical this operal direction	Η,	27. Manner of Death 28	a. Date of Injury (Month, Day Year		28c, injury Work	4 Nursing Hor	ne 5 Hesidena 28d. Describe how	ce 6 Other (Sp injury occurred	pecify)				
ion	ending Feath. or: After he funer	atio	2 Accident investigation	(Month, Day rear) Injury		res 2□No							
N X	or Atta	Certification:	3 Suicide 6 Could not be determined 28	le. Place of Injury · A building, etc. (Spe	t home, farm, stre ecify)	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or I State)	Rural Route Number,				
_	To the Hospitel or Attending P within 24 hours after death. To the Funerel Director: After t completely filled in by the funera	edicai Ce	29a. Certifier (Check only one) 1 Certifying Physicial 2 Medical Examiner:	In the basis of exam	knowledge, death ination and/or inv	occurred at the timestigation, in my op	e, date and place, a inion, death occurre	and due to the caused at the time, date	se(s) and manner a	as stated. ue to the cause(s)				
	o the vithin 2 To the	Mec	29b. Signature and title of pertifier	and manner stated.		29c. License	number	29d	. Date signed (Moi	nth, Day, Year)				
	2 - 0		· Chr	MD		PITE	-72	A	rugust 2	4 2005				
1 1	H.7		30. Name and address person who comple Evonne Fontanilla		tem 23a) (Type, F	Print) Iteene S	St Ball	timore	MD 21	201				
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	_	111		And the second	/-	Chiles .								

		1- State C State C Registrar	of Maryland	/ Depail Cert	tment of F ificate of	lealth and I Death	Mental Hy	giene 2	005	2962	
Physic /Med		1. Decedent's Name (First, Middle, Last) Mary F. Roman					2. Date of De Month 08/23/	Day	Year	3. Time of Death	
Exami		4a. Facility Name (If not institution, give street and no Suburban Hospital	ımber)		4b. City, Town, o	r Location of Death		4c. Cour	nty of Death	111111111111111111111111111111111111111	
Funeral Director		5. Social Security Number 6. Sex 1 M 2 XF	7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 03/07/	eth.	9. Birthp	lace (State or Foreig try) esota	
Maryland -f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Georges	10c. City, T	Town or Loca	ition				11	0d. Inside City Limits	
h with the 23a or 28a set be noti	al Director	10e. Street and Number 7405 Central Avenue			10f. Zip Code 20743			10g. Citizen o	of What Country? Nace - American Indian, Black, White, etc. city: White (Business/Industry) Ome Name) No. State, Zip Code) 3 n - City or Town, State nd, MD Funeral Home 20715 Approximate Interval Between Onset and Death Onset and Death Date of delivery Month Day Year		
be filed within 72 hours after death with the Maryland tal Hygiene. Individual than "natural", or Iteme 23a or 28a-f show event, it a Medical Examinar must be notified at	by Funeral	Armed F	2∭No ive		as Decedent of H res, specify Cuba	lispanic Origin? (Si an, Mexican, Puerto Specify:	Decify Yes or No Rican, etc.)	5 14. R. B. Spec	ack, White, o	etc.	
id a should be filed within 72 hours aft its and Mantal Hygiene. 27 is marked other than "natural", or traumatic event, it a Madical Exprintition.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decede (Give ki life. DO Home M		ation during most of won d)	king		Business/Inc		
should be filed with of Mental Hygiene. marked other than matic event, Italy	To Be Co	10 17. Father's Name (First, Middle, Last) William Fedors	1	nome v	laker	18. Mother's Nam					
		19a. Informant's Name/Relationship (Type, Print) Catherine A. Roman/ Daug	1				ral Route Numb	er, City or Tow		Code)	
00		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	ion (Name of tory or other place Nations tery	a1 08/2	Date	Suitlar	nd, MD				
permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee		16	000 Anna	apolis Ro	ad Bowi	e, MD 2		al Home	
Physician /Medical Examiner	J.	Due to	each line. CONGES (or as a consequen	Tive						Interval Between	
ificate be executed g physician and as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	(or as a consequent								
the death certing the attending	Physician/Med	in the past 12 months?	tcome of pregnancy birth 2 Fetal de nant at time of death own	ath 3 □E	ctopic pregnancy other (specify)					•	
w requires that been signed by should be deta	b	Part II. Other significant conditions contributing to d	eath but not resultin	ng in the und	erlying cause give	en in Part I.		obacco use cor Yes 2 No			
	Completed								prior to com death?	sy findings available pletion of cause of	
								dence 6 Ot)	
lal or Attending s after death. si Director: After ed in by the fune	9 3 Suicide 6 Could not be								ber or Rural	Route Number,	
To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	edical	29a. Certifier (Check only one) Certifying Physician: To the bandical Examiner: On the band man	a best of my knowled asis of examination ner stated.	dje, death o and/or inves	courned at the time	a, date and class pinion, death occur	and due to the red at the time,	rause(s) and n date and place	am or as sta , and due to	ited. the cause(s)	
To the within 2 To the complete	N		a, v			number 57(2)		29d. Date sign	ed (Month, D		
		30. Name and address of person who completed cause Truong Bao, MD, 5622 Sh	ields Dri	ve Be		MD 20817				. Vir.—	
Sta Regist	ate rar	31. Date filed (Month, Day, Year) AUG 2 5 2005	legistrar's Signature	Sport	de						

may F. Roman 08/23/05/1644

			For State Registrar	State of I	Maryland /	Depa Ce	artmen	t of H	ealth a	and M		giene	/ 1111 ~	2962	1
	Physici /Medi	al	Decedent's Name (First, Middle, FRANCES 4a. Facility Name (If not institution,			ROWE	4h City	Town or	Location o		2. Date of Dea Month AUGUST	25		3. Time of Death	
	Examir Funeral	ier	Frederick Memo	rial Hospi	tal Age (In yrs. last L			redei			8. Date of Birt NOV . 1 3	I	Frederic	olace (State or Foreign	,
	Director *1 show	tor	Usual Residence of Decedent 10a. State 10b. County	lerick	10c. City, To	Yrs.					NOV.13	, 19		intrologiand 10d. Inside City Limits 1 □ Yes 2 🎖 No	_
	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show ant, the Medical Examination institution at	by Funeral Director	10e. Street and Number 11862 Good In		.5		10f. Zip	Code	21757				izen of What Cour	•	_
900	hours after de ural', or item il Examinati	d by Fund	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	If Yes, Give Year or Date	s? ⊡ No s:		1 ☐ Yes 2	2 ⊠ No	Specify:	gin? (Spe , Puerto f	cify Yes or No- Rican, etc.)		14. Race - Americ Black, White, Specify: Whi	etc. te	
Maryland 21215-0036	ed within 72 ygiene. Her than "nat I, the Wedic	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4d		(Give	dent's Usua kind of wor DO NOT us Seam:	k done di le retired) stre:	uring most				sewing		
aryland	should be fill nd Mental Hi marked oth	To Be	17. Father's Name (First, Middle, L Robert Lee G 19a. Informant's Name/Relationshi	reen	19	9b. Mailir	ng Address		Edn	a Ma	(First, Middle, rie Bla	xste		Code)	_
nore, Με	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or othar traumatic evant, the Medical Example or ust be published at once.		Joan Parsley/ d 20a. Method of Disposition 1 월 Burial 2 □ Cremation	3 □Removal from Sta	20b. Place cemet	1862 of Dispo	2 Good sition (Nam natory or ot	d Int	tent	Rd.	Keym	ar, 20c. Lo	MD 2175	own, State	-
Baltimore,	permit. P. Departme Important any injury		21. Signature of Furferal Service Licensee 22. Name and Address of Facility Hartzler Funeral Home 6 E. Broadway Union Bridge, MD 217 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,												
	Prysician /Medical Examiner	iner	snock, or neart failure. List of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	aDue to (or ab.	ed the death. Do	di e of):					respiratory ari	est,		Approximate Interval Between Onset and Death	
68760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	edicai Examiner	Cause (Disease or injury that initiated avents resulting in death) Last	c	as a consequence	e of):									_
O. Box	that the death certificated by the attending placed for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2☐No 9 ☐ Unknown		2 Fetal deat at time of death		Ectopic pre Other (spe					2	23d. Date of delive Month	ory Day Year	
Records, P.	w requires that been signed t should be det	by	Part II. Other significant condition	Reun [but not resulting	in the ur	nderlying ca	iuse giver	n in Part I.			baccous		ne cause of death?	
tal Rec	iician: The law i certificate has bu rector, page 2 st	e Completed	Preumonia 25. Was case referred to medical		د ۱۵ ر				OR Diago	of Dooth	24a. Was a autops perform 1 Yes	med? 22 No	24b. Were autoprior to condeath?	osy findings available npletion of cause of 2 No	
Division of Vital	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to	ation: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Notural 5 Pending 2 Accident investiga	tion		outpatien Time of Injury		Other	4 □ Nurs	sing Hom		ence 6	Other (Specify)	
Divis	To the Hospital or Attanding Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	al Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could no determin	uld not be			t the time	date and	I place, ar	City or Town	n, State)	d Number or Rural	atod		
		Medical	(Check only 2 Medical Expensions) 2 Medical Expensions Medical Expensions (Check only one) 2 Medical Expensions (Check one) 2 Medical Expensions (Check only one) 2 Medical Expensions (Check one) 2 Medical Expensions (Che	caminer: On the basis and manner	of examination a	nd/or inv	estigation,	License	nion, death	h occurred	at the time, d	ate and 9d. Date	place, and due to signed (Month, L	the cause(s) Day, Year)	_
	W310 Sta	te.	30. Name and add a s of person w Lere Any You S 31. Date filed (Month, Day, Year)	PIA MO	172	The	Print)	Sch					derick M		2
	Registr		AUG 2	9 2005	trar's Signature	× 1	porte								

			1 - State of State of Registrar	Maryland / Dep	partment of leartificate of	Health and I Death	Mental Hy	giene Reg. No. 200	5 29626
	Physici /Medi		Decedent's Name (First, Middle, Last) ROBERT A	ACEY RYDER			2. Date of Dea Month		3. Time of Death
	Examir		4a. Facility Name (If not institution, give street and number CARROLL HOSPITAL CENT			or Location of Death		4c. County of De	ath
	Funeral Director			. Age (In yrs. last birthday 77 Yrs.		If Under 24 Hrs.	8. Date of Birth (Month, Day 2/28/	h 9. B	irthplace (State or Foreign Country) RGINIA
	Maryland e-f ehow iffed et	tor	10a. State 10b. County MD CARROLL	10c. City, Town or L	ocation INSTER				10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	3a or 284	i Director	10e. Street and Number 1325 NICODEMUS RD.		10f. Zip Code 211	57		10g. Citizen of What (Country?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 ie marked other then "naturel", or iteme 23a or 28e-f show any figury or other treumatic event, the Medical Examinat must be notified at anone.	by Funeral		∆ No	Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Arr Black, Wh	
21215-0036	d within 72 ho giene. er then "natur the Medical.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4)	(Give life.	edent's Usual Occup e kind of work done DO NOT use retire CARETAKI	during most of world)		16b. Kind of Busines	•
yland	ould be file Mental Hy arked othe atic event,	To Be (17. Father's Name (First, Middle, Last) BIAS	RYDER		NELLI	E	Maiden Sumame) THACKER	
e, Mar	t and 2 shi Health and Sm 27 le m	. 09	19a. Informant's Name/Relationship (Type, Print) DEBORAH RYDER - DAUG 20a. Method of Disposition	19b. Mail GHTER 1325 20b. Place of Disp	NICODE		WESTM		MD. 21157
Baltimore, Maryland	iit. Pages urtment of h intent: If ite njury or of		1	FALLING PRESBYTE	mators or other plan	JRCH CEM	7/05	20c. Location - City o	
Ba	Department of the partment of			2	54 E. M	AIN ST.,	WESTMI	NSTER, M	НОМЕ D. 21157
	Physician /Medical		23a. Part1. Enter the disease, or complications that cau shock, or teart failure. List only one cause on each limmediate Cause (Final disease or condition resulting in death) a	WEL IN	FARCT		or respiratory arr	est,	Approximate Interval Between Onset and Death
8760,	cate be executed by the burial-transit can be executed the burial-transit can be executed the burial-transit can be executed to the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	as a consequence of): as a consequence of): as a consequence of):					
.O. Box 68	The law requires that the death certifics tto has been signed by the attending phage 2 should be detached for use as t	Physician/Med		n 2 Fetal death 3[It at time of death 5[□Ectopic pregnancy □ Other (specify) _			23d. Date of de Month	livery Day Year
۵.	w requires that been signed by should be deta	by	Part II. Other significant conditions contributing to deat ASCVD	h but not resulting in the u	ınderlying cause gıv	en in Part I.		pacco use contribute t	o the cause of death?
al Records,		Completed		/			24a. Was a autops perform	v prior to	utopsy findings available completion of cause of
of Vital	Physician: this certific al director,	To Be		atient 2 ☐ ER/Outpatier	nt 3 DOA Oth	26. Place of Deat er: 4 ☐ Nursing Ho		e) ence 6 □Other (Spe	ocify)
Division of	Hospitel or Attending Physician: 44 hours alter death: Funeral Director: After this certific tely filled in by the funeral director,	Certification;	27. Mann f Death 1 atural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		M 1 🗆	y at k? Yes 2 □ No		w injury occurred	
N N	pitel or A burs after erel Direc illed in by		4 Homicide determined 256. Place of building,	Injury - At home, farm, str, etc. (Specify)			City or Town		
	To the Hospitel of within 24 hours at To the Funerel D completely filled it	Medical	29a. Certifier (Check only one) 1 Pertifying Physician: To the best of the desired from the past one) 2 Medical Examiner: On the basic and manner 29b. Signature and with the certifier	s of examination and/or in	h occurred at the time vestigation, in my of 29c. License	pinion, death occur	red at the time, da	ate and place, and due	e to the cause(s)
	MY		Eman J	AU		04431		od. Date signed (Mont	
	w s		30. Name and address of person who completed cause of			O MEM		IVE, WES	TMINSTER
	Sta Registra	_	31. Date filed (Month, Day, Year) 32. R 32	rar's Signature				^	10 21157

			For State Registrar	State of Maryl			of Health of Death		R	eg. No. 2	005	29627
	Physici	an	1. Decedent's Name (First, Middle, Last) Pauline Anne Roma						2. Date of Dea Month 08/23/2		Year	3. Time of Death 12:05 P M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Tov	wn, or Location	of Death	00/20/-		ty of Death	
	LXdIIII	ici	12413 Shelter Lan			Bowie				Princ	e Geo	orges
	Funeral		Social Security Number 6. Sex	THE OFTE	yrs. last birthday)	If Under 1 Y Months D	fear If Unde lays Hours	r 24 Hrs. Min.	8. Date of Birth (Month, Day 10 / 28 /]	Year)		place (State or Foreign ntry)
	Director		168-18-0392 Usual Residence of Decedent	8	4 Yrs.				10/28/	1920	Penn	isylvania
	/land		10a. State 10b. County	100	: City, Town or Lo	ocation					1	0d. Inside City Limits
	a-f sh	ctor	Maryland Prince Ge	orges	owie							1X Yes 2 □ No
	ih the	Dire	10e. Street and Number			10f. Zip Co			1	log. Citizen of	What Cour	ntry?
	s 23a	- La	12413 Shelter Lane		in 11 C 12	2071		rigin? /Cn	acifu Vas ar Na-	USA 14 Bs	ice - Americ	can Indian
36	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygene Item 27 is marked other then "neturel", or items 23a or 28e-f show other treumetic event, the Medical Examiner must be neitlied at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 🏋 No If Yes, Give Year or Dates:		was Decedent If Yes, specify	Cuban, Mexica	an, Puerto	ecify Yes or No- Rican, etc.)		ack, White,	etc.
9	2 hou seture ical E	ted	15. Decedent's Edu		16a. Dece	dent's Usual C	occupation	set of work	ing	16b. Kind of		
21215-0036	thin 7 e.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use r	retired)	ISI OI WOIK	mig	0 11		
12	e filed within al Hygiene. I other then '		12 17. Father's Name (First, Middle, Last)		Home	Maker	18 Mot	her's Nami	e (First, Middle,	Own Ho		
and	ntal H ed ot	Be	Matthew Tunella					y Lik		walder cama	11107	
Maryland	2 should and Men is marke eumetic	10	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Maili	ng Address (S			al Route Numbe	r, City or Town	n, State, Zip	Code)
	is 1 and 2 of Health a item 27 is other trei		Carol Lea Roman/ I	aughter	1241	3 Shelt	er Lan	e Bow	ie, MD_	20715		
ore	of He of He if item		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ F		b. Place of Disposition Comments of Comments of the Comments o	osition (Name matory of othe OT	of Hece)Bles	ssed		20c. Location	·	
Ĕ	Pag Iment tant: I		`4 ☐ Donation 5 ☐ Other (Specify)	7	/irgin Ma	ary Cem	netery	8	/26/2005			
Baltimore,	permit. Pages: Department of P Important: If ite any injury or of		21. Signature of Funeral Service Licens		1	6000 An	napoli	s Roa	ert E. l d Bowie	, MD 20		Approximate
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or complished, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate causs. Enter Underlying	Due to (or as a cor	nsequence of):	t	Can					Interval Between Onset and Death
68760,	death certificate be executed e attending physiclan and of for use as the burial-transit	dical Examine	Cause (Disease or injury	Due to (or as a cord.	nsequence of):							
.O. Box		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pr 1	Fetal death 3	⊒Ectopic pregi ⊒ Other <i>(speci</i>					ate of deliver	ery Day Year
rds, P	equires that en signed b ould be deta	by	Part II. Other significant conditions co	ntributing to death but no	t resulting in the t	anderlying caus	se given in Par	t I.	23e. Did to			he cause of death? pably 4 ⊟Unknown
I Record	The law re ate has be page 2 sho	Completed							24a. Was a autop: perfor 1 Yes	sv	prior to co death?	ppsy findings available impletion of cause of 2 No
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Other		h (Check only or			
of	Phys this aldii	2	1 Yes 2 No	1 Linpatient	2 ER/Outpatie		. Injury at Work?	Nursing Ho	ome 5 Tesid 28d. Describe h	ence 6 □O ow injury occu	1-1	(y)
	Attending I r death, ector: After by the funer	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yea	ar) Injury	м	Work? 1 ☐ Yes 2 [□No				
Division	- 0	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, si pecify)	reet, factory, o	office		28f. Location (S City or Tow		nber or Rura	al Route Number,
	To the Hospital or within 24 hours afte To the Funeral Direction completely filled in the comple	Medical C		sician: To the best of my iner: On the basis of exa and manner stated.								
	To the within To the comp	ž	29b. Signature and title of certifier	1/	4	29c. L	icense numbe	1	, 2	29d. Date sign	ed (Month,	Day, Year)
			1 Curlis	Harris	MO		1153	50	6	47	-3/0	19
-			30. Name and address of berson who co	uno 900	(Item 23a) (Type	gate	Rel	SAP	7-11 A.	nnapo	115	2146 MD
	St Regist	ate trar	31. Date filed (Month, Day, Year) AUG 2 4	32. Registrar's \$	J J	Sport	0					

	-	For Stete	State of Maryland	•	artment of F			giene Reg. No. 20	กร	20620
		Registrar 1. Decedent's Name (First, Middle, Last				Dour	2. Date of Dea	ith Day	Year	3. Time of Death
Physici /Medi	cal	Powell E 4a. Facility Name (If not institution, give	<u> </u>	binsor		or Location of Death	Sep 3, 2	4c. County o	f Death	3:50 am ^м
Examir	ner	Allegany County N			Cumber			Allega		
Funeral Director		5. Social Security Number 6. Se 215-20-6944	7. Age (In yrs. la 78	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Oct 10	, 1926	9. Birthpla Count MD	ace (State or Foreign ry)
death with the Maryland ims 23a or 28a-f show ground be notified at	ō	Usual Residence of Decedent 10a. State 10b. County MD Allegan		, Town or Lo Cumb	cation perland				10	0d. Inside City Limits 1 □Xes 2 □ No
r 28a-i	irect	10e. Street and Number			10f. Zip Code			10g. Citizen of W	nat Count	ry?
ath with	ralD	807 Sunbury Aven		2 40.1	1	21502	- asifu Van as Na	US 14. Race		an Indian
5-UUSD 72 hours after de natural', or Itemi	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		f Yes, specify Cub	dispanic Origin? (S an, Mexican, Puerl Specify:	o Rican, etc.)	Black Specify:	, White, e	etc.
LIZIS-UUSO 4 within 72 hours after death with the Marylan Jiene. rithen "natural", or items 23e or 28e-f show Itte Medical Examiner must bu notified at	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	de completed) College (1-4ar 5+)	(Give life. l	DO NOT use retire	during most of wor		16b. Kind of Bus	iness/Ind	
Hygien ther th		17. Father's Name (First, Middle, Last)		Labore	er	18. Mother's Nar	ne (First, Middle,	Plumbers Maiden Sumame		
land be full b	To Be	Powell Aubrey R	obinson			Lois (F	Ravenscr	oft) Robir	nson	
y, Maryland z and 2 should be filed eath and Mental Hyg m 27 is marked othe her traumatic evant,		19a. Informant's Name/Relationship (7) Delores Robinson	ype, Print) wife	19b. Mailir 807	ng Address (Street Sunbury A	and Number or Ru Avenue		er, City or Town, S erland	itate, Zip V	^{Code)} 1D 21502
Baltimore, I permit. Pages 1 and Department of Healt Importent: If itam 2 any injury or other once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Removal from State	emetery, crer	sition (Name of matory or other pla emorial Gai		9/6/2005	LaVale	City or Tov	wn, State
certificate be executed xd with a continuation and contin	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	rence of):	on's	bstanc	tve l	uny di	ala	Onset and Death
Certifi certifi nding I	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	death 3	⊒Ectopic pregnanc	у		23d. Date Mon		ry Day Year
ds, P.O. I	è	Part II. Other significant conditions of	ontributing to death but not resu	alting in the u	nderlying cause gr	ven in Part I.				e cause of death? ably 4 Unknown
Division of Vital Records, P.O. Bo or Attending Physician: The law requires that the death after death. Director: After this certificate has been signed by the atter in by the funeral director, page 2 should be detached for u.	Completed						1 ☐ Yes	osy primed? di 2 No 1	ere autop for to con eath?	osy findings available inpletion of cause of
Vita sician certifi irector	Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DOA Ot		ath <i>(Check only o</i> Home 5 🗆 Resid		r (Snecify	-
Vision of Vital Attending Physician: or death. ector: After this certifical	tlon; To	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Inju			now injury occurre		,
Division of To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, sti	reet, factory, office		28f. Location (S City or Tov	Street and Numbe vn, State)	r or Rurai	Route Number,
Div To the Hospitel or A within 24 hours after To the Funeral Dire completely filled in b	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exen	ysicien: To the best of my kno niner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the to vestigation, in my	ime, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and mar date and place, a	ner as stand due to	ated. the cause(s)
ro the vithin 2 ro the comple	Med	29b. Signature and title of certifier	and mariner states.		29c, Licen	se number		29d. Date signed	(Month, L	Day, Year)
(/		30. Name and address of person who	completed cause of death (1)	L. ()	Print)	14865		SEPT.	3 20	2005
n		30. Name and address of person who Robustiano Barre	/			ed Bldg Cu	ımberlan	d MD 21	502	
Si Regis	ate	31. Date filed (Month, Day, Year)	32. Hegistrar's Signa	ture	parti	g - O				

			For Stete Registrer		State of	Maryla	and / Depa <i>Ce</i>	artmen rtificate	t of H e of i	lealth Death	and M		giene, Reg. No.	Z 11 11 5	2962
			Decedent's Name	First, Middle	, Last)							2. Date of De	ath		3. Time of Death
	Physic /Medi		Alvin	Mar	rs		Roberts	5				Month August	Day 21.	Year 2005	8:45 A M
	Exami		4a. Facility Name (I	f not institution	give street and num	nber)		1	Town, or	Location	of Death			County of Death	
					of Bethes				hes					ontgome	ry
п	Funeral		5. Social Security N 231-16-22		6. Sex 1 ☑ M 2 ☐ F		rs. last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir 2 / 28 / 1	th y. 7 S ar)	Col	nplace (State or Foreigr untry)
	Director		Usual Residence of			80						2,20,1		Virg	ginia
	ylanc how		10a. State	10b. County		10c.	City, Town or Lo	ocation							10d. Inside City Limits
	e Marita	ctor	RI	Provid	dence		Provide	nce							1 ☐ Yes 2 ☐ No
	h with th	al Director	10e. Street and Nur 128 Woodb		reet			10f. Zip	Code	029	06			en of What Cou USA	untry?
936	be filed within 72 hours after death with the Maryland hat Hygiene. Id chher then "neturel", or Items 23a or 28a-f ehow event. The Modical Exercitate cost by notified at	by Funeral	11. Marital Status 1 ☐ Never Marri 3 ☑ Widowed		12. Was Dece Armed For ed 1 Tyes If Yes, Giv Year or Da	ces? 2 🗌 No		Was Deced If Yes, spec		ispanic Or in, Mexical Specify:		ecify Yes or No Rican, etc.)		4. Race - Amer Black, White Specify: W	
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lai	should be ind Mental marked o umetic eve	70	William	Went Ro	oberts					La	rmie	Mae Per	rkins		
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	Physician		Immediate Cause (Final			Cardio	mvopa	thv						Onset and Death
	/Medical Examiner		resulting in death)	19	-		equence of):	<i>y</i> - F							
П	Examine	ь.	Sequentially list cor	nditions,		erten									
	ped list	Examiner	dany, leading to incause. Enter Unde Cause (Disease or	rlying injury	Due to (c	if als a cons	equence oi).								
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O. Box	he death certilicate be executed the attending physician and ched for use as the buriat-transit	hysician/Me	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?		th 2 ☐ Fe int at time o	etal death 3	Ectopic pre Other (spe					23	d. Date of deliv Month	ery Day Year
σ.	that the ned by the detacher	Д.	Part II. Other signifi	cant condition	ns contributing to dea	ath but not r	esulting in the u	nderlying ca	use give	n in Part I.		23e. Did to	bacco use	contribute to t	he cause of death?
Records,	w requires been sign should be	d by										1 🗆 Y	es 2√2	No 3 ☐ Prol	bably 4 Unknown
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of V	S S	2	examiner? 1 ☐ Yes 2 🔀	No			☐ ER/Outpatien	t 3 🗆 DO	A Othe	r: 4 ₺ Nu	rsing Hor	ne 5 Resid	ence 6	Other (Special	(y)
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Sio	Attending r death. sctor: After by the fune	cat	2 Accident 3 Suicide	investiga 6 🗆 Could no	nt he			M	-	/es 2 □ I					
Division	or Attencater death	Certification;	4 Homicide	determin	ned 28e. Place of building	g, etc. (Spe	home, farm, str cify)	eet, factory,	office		2	8f. Location (S City or Tow		Number or Rura	al Route Number,
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	the Hin 24 the Fu	ledical		Z Medical E	xeminer: On the bas and manne	PIS OF BYSTILL	nation and/or in	estigation,	in my op	inion, dea	th occurre	ed at the time, o	late and pl	lace, and due to	o the cause(s)
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	3		Dr. Alpa	ha Gosw	mo/completed cause	11119	Rockvi		ike	Suite	G-1	00; Roc	kvill	Le MD 2	0852
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			For State Registrar	State of M	laryland		artment of rtificate o					2005	296	30
			1. Decedent's Name (First, Middle	e, Last)						2. Date of Deal	th Day	Year	3. Time of D	eath
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	Examin		4a. Facility Name (If not institution	n, give street and number)		4b. City, Town	n, or Location	of Death		4c. C	ounty of Death		
			25016 Oak Driv					mascus				Montgom		
	Funeral		5. Social Security Number	6. Sex 7. A 1⊠M 2□F		ast birthday) Yrs.	If Under 1 Ye Months Day		Min.	8. Date of Birth (Month, Day	Year)		place (State or F ntry)	-oreign
	Director		215-46-4950 Usual Residence of Decedent		58					Sept. 1	/,194	+6 Ma	ryland	
	land ow		10a. State 10b. County	-	10c. City	, Town or Lo	cation						10d. Inside City	Limits
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	r 28g	Director	10e. Street and Number	- CBOMOLY			10f. Zip Cod	е		1	0g. Citize	n of What Cou	ntry?	
	th wit	a D	25016 Oak Drive	2				20872			Uni	ited St	ates	
	ems strum	Funeral	11. Marital Status	12. Was Decedent Armed Forces		S. 13.	Was Decedent of If Yes, specify C		igin? (Spec	ify Yes or No-		Race - Ameri Black, White	can Indian,	
9	or It	y Fu	1 X Never Married 2 Mar	ned 1 ☐ Yes 2 🛭 If Yes, Give	No	h	1□Yes 2█1			,,	s	necify:		
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Maryland	2 should be fited withir and Mental Hygiene. Is marked other than aumatic event, tre M	-	19a. Informant's Name/Relations			19b. Mailir	ng Address (Stre				City or 7	Town, State, Zi	o Code)	
	and 2 saith a n 27 is		Mary Bolling/	Sister		25012	Oak Dr	ive, D	amasc	us, Mai	ylan	d 2087	2	
Baltimore,	- F 5 5		20a. Method of Disposition 1 Burial 2 □ Cremation	3 DRomausi from State	1 ~	lace of Dispo	sition (Name of matory or other)	place) {	3/287	2005	20c. Loca	ation - City or T	own, State	
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8760,	Physician /Medical Examiner up processing the private remaining th	cal Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. So Day to (or a Dua to (or a c.	oho	raliano de la	l Ca plen ry c	rein lista	ema As	with r lusio	reta	stasis_	Interval Betwee Onset and De 4 men 3 men 9	
O. Box 6	death certific e attending pl ed for use as t	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Ves 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregna Other (specify,				23	d. Date of deliv Month	ery Day Yea	ar
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I Records,	The la ate has page 2	Completed			<u>.</u>					24a. Was a autops perform	ned2	prior to co death?	opsy findings ava impletion of cau	ailable se of
Vital	Physicien: r this certific ral director,	Be (25. Was case referred to medica examiner?							(Check only on	A			
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ň	ling F	lo	27. Manner of Death 1 Natural 5 ☐ Pendir		ay Year)	28b. Time of Injury		njury at Work? I □ Yes 2 □		3d. Describe ho	ow injury o	occurred		
isic	Attending ir death. ector: After by the fune	icat	2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could	not be One Place of In	niury - At ho	me farm str	eet, factory, offi		-	Rf Location (St	reet and i	Number or Rur	al Route Numbe	or.
Division	or fte	Certification:	4 Homicide determ	building, e	etc. (Specify	<i>(</i>)	oot, ractory, one	Ç		City or Town	, State)	vanibor or rigi	ar 1 10010 74011100	*,
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical C	29a. Certifier 1 Certifyin (Check only one) 2 Medical	ng Physician: To the bes Examiner: On the basis and manner s	of examinat	wledge, deat tion and/or in	h occurred at the vestigation, in m	e time, date ar ny opinion, dea	nd place, ar ath occurre	nd due to the ca	ause(s) ar ate and p	nd manner as s lace, and due t	stated. o the cause(s)	
	To th withir To th compl	Me	29b. Signature and title of certifie	or //	/		29c. Lic	ense number	•	2	9d. Date :	signed (Month,	Day, Year)	
			Charles (N./anes	low	-	D	21726			Augus	st 26,	2005	
	10		30. Name and address of person	who completed cause of	death (Item	23a) (Type,								
	10		Charles W. Kar				d, Dama	scus, 1	Maryla	and 208	72			
	Sta Registi		31. Date filed (Month, Day, Year,	G 2 9 2005	trar Signa		1	٠.						
	ricgisti		AU	U & 3 4000	MANUAL STATES	US	KINGAL	4						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Rag. No. 2005 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 12:13 P M 24 2005 August Daniela Retana /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Mount Airy 4145 Walnutwood Court If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 13, 1992 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Maryland Director 218-35-4395 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23e or 28e-f show 10d. Inside City Limits 10c. City, Town or Location any injury or other traumatic event, the Modical Exeminational be notified at once. 10a. State 10b. County 1 ☐ Yes 2 No Director Maryland Frederick Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21771 United States 4145 Walnutwood Court Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give 1 1 Never Married 2 Married Specify: White 1 ☑ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 δ Costa Rica 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Middle School Student 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Yamileth Mora 2 Julio Retana 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4145 Walnutwood Court Mount Airy, Maryland 21771 Julio Retana / Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition August 29, Frederick, Maryland 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ° 4 □Dopation 5 Other (Specify) Frederick Crematory 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of mera Service Licensee 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Roma Small Round-Cell Carcingma Desimoplastic **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine or Attending Physicien: The law requires that the death certificate be executed the attending physicien and ched for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown sate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the hours after deatl 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel (🌠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 1)46930 Contona 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 Executive Pank CT Germantown Lillian M. Cardona Mo 32. Regisfar's Signature & Lynchia 31. Date filed (Month, Day, Year) State AUG 2 9 2005 > Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 2005 12:06 A Michael Sabadish August 31 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Laurel Laurel Regional Hospital If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months 1**X** M 2 □ F Yrs. 202 - 10 - 8939 10/9/1918 PA Director 86 Usuel Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City. Town or Location Iteme 23e or 28e-f show other treumetic event, the Medical Examiner must be notified at 1 XYes 2 □ No Director Mechanicsburg Cumberland 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number with **USA** 235 West Locust Street 17055 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 "naturel", or Specify: þ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then any injury or other trainment. Elementary/Secondary (0-12) College (1-4or 5+) Mining 8 Miner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sabadish Anna Hritz Michael 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 235 West Locust Street Mechanicsburg, PA 17055 Anna T. McKendrick 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Lewellyn, PA 17944 4 □ Donation 5 □ Other (Specify) St.Mary Cemetery 9/2/2005 22 Name and Address of Facility 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Day Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed the attending physicien and hed for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months?

1 Yes 2 No
9 Unknown 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown has been signed by 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 No or Attending Physicien: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 Yes 2 No investigation within 24 hours after death. To the Funerel Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Unceleson n. D0036716 August 31, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8317 Cherry Lane, Laurel, MD 20707 Andrew Kundvat, MD 31. Date filed (Month, Day, Year) 32. Pristrar's Signature State 2 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** September 4 2005 1054 AM Ralph Wayne Shelby, Sr. /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Cecil E1kton 22 Pinder Avenue If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, April 20, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1∭M 2□F 53 Director 219-58-0912 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h County 10a State Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If item 27 is marked other then "natural", or Items 23a or 28a-1 show ury or other traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Ceci1 E1kton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21921 United States 22 Pinder Avenue Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: lf Yes, Give Year or Dates: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Diesel Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Isham Chesley Shelby, Sr. Norma Elizabeth Dill ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 22 Pinder Avenue, Elkton, Maryland 21921 Tina M. Shelby/Wife 20b. Place of Disposition (Name of cometery, crematory or other place Church of Christ Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State September 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. *4 ☐ Donation 5 ☐ Other (Specify) 8, 2005 Elkton, Maryland Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 21. Signal re of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death helasta lic Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical attending p for use as as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, by 1 ☐ es 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 Tyes 2 No 1 Yes 2 No Division of Vital Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Thesidence 6 Other (Specify) _2 No 1 🗌 Yes 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After Certification: 5 Pending investigation 1 ZNatural 1 ☐ Yes 2 ☐ No after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital o within 24 hours af To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of 3565 6 30. Name and address of person who completed cause of death (term 23a) (Type, Print) 111 West High Street, Suite 104, Elkton, Maryland 21921 Martha Hosford, M.D., 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month OB carboroug **Physician** TEORGE 3:45am 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Crisfield
If Under 24 Hrs. 8. Bryd lawes Nusing H Home omerst 5. Social Security Number If Under 1 Year Months Devs **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Deys 1 XM 2□ F Hours 220-32-8105 Usual Residence of Decedent Director MD permit. Peges 1 end 2 should be filed within 72 hours effer death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is merked other then "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits MD Director 1 ☐ Yes 2 No Domerset arion 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21838 5500 Koad **BIVENS** Funerai 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) aborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JCar borough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) toria Scarborough - Wife 5500 Bivens RD MD Marion 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Crisfield Asbura Cemerary
22. Name and Address of Facility 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee At thong & Ward Funcia 30439 Hampy Ar Proposed or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory 8. Ward funcial Are Princess MO 21853 **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) ALZHeimer's Demension Examiner Examiner or Attending Physician: The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dld tobacco use contribute to the cause of deeth? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were eutopsy findings available prior to completion of cause of deeth? funeral director, page 2 should 24a. Was en autopsy performed? To the Hospital or Attending Physician: The law within 24 hours efter death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 1□ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 12 Certifying Physicien: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 05 30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print) remos 31. Date filed (Month, Day, Year) 32. Regi ar's Signature State Registrar AUG 2 6 2005

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

					State of iv	iai yiai	•	tificate		Death		Reg. No.			
			1. Decedent's Name	(First, Middle, Las	t)						2. Date of De Month		0.05	3. Trae	Openthy I
В	Physici /Medic		Helen Jea	nnette S	ausman						Septem	per 1,	2005	7:4	B PMO
	Examin		4a Fecility Neme (If	not institution, give	street end number	·)			4	b. City, Town, or I	ocation of Death		ty of Death		
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	Funeral Director		5. Social Security No. 283–14–21	10 1	9X 7. A □M 21X F		last birthday) 83 Yrs.	Months D	ays	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da July 2	, 1922	9. Birthpl Count Mary	ace (Stet Land	e or Foreign
	pue *	-	Usuel Residence of 10a. State	10b. County		10c. Cit	y, Town or Loca	ation					10	Od. Inside	City Limits
	Mery III	ţō	MD	Garrett		Fri	endsvil	le						1 🗆 Y	es 2 🗓 No
	r 28e	9	10e. Street end Num					10f. Zip Co	ode			10g. Citizen of	What Coun	try?	
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336	within 72 hours after death with the Meryland ane. than "natural", or heme 23e or 28e-f show na Medical Examiner must be notified at	Completed by Funeral Director	11. Merital Status 1 Never Merrie 3 Widowed	ed 2 Married	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	? N o		as Deceden Yes, specify		spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)	Spec	ace - America ack, White, e	etc.	
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and	ntel H	To Be	James B.							Emma Fr		Maiden Sunia	me)		
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Baltir	permit. Peges Department of I Important: If Ite eny Injury or of		21. Signature of Fur	neral Service Licen		/ Aut	22.	Name and A	ddres	s of Facility Ne	wman Fu	neral H			
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Box	d for u	Clar	Pert II. Other signific	ant conditions co	ntributing to death	hut not res	ulting in the unc	tertving caus	e dive	n in Part I	23b. Did 1	obacco use c	ontribute to	the caus	e of death?
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DIV	tal or Att rs after d el Direct led in by	Certif	3 ☐ Suicide 4 ☐ Homicide	determined	28e. Placa of Ir building, e	ijury - At ho tc. (Specif	ome, farm, stree	et, factory, of	fice		28f. Location (5 City or Tox		ber or Rural	Houte No	umber,
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only one)	2 Medical Exam	sician: To the best ner: On the basis of and menner s	ot examina	wledge, death o tion end/or inve	stigation, in	my op	inion, death occur	rred at the time,	date and place	, and due to	the cause	
)	With To the	Σ	29b. Signature end t	itle of certifier	Su			29c. Li	cense	73333		29d. Date sign	ed (Month, D	ay, Year)	
			30. Name end addre							0 -1 1	1 100	21552			
	Sta	te	31. Date filed (Month			311 rer's Signe	ture	on Str	eet	: Oaklar	ia, MD	21550			

			1 - For State Registrar	State of Mar		artment of rtificate o		ind Mental H	ygieni Reg. No	e 20	05 2	96:
	Physic /Medi		Decedent's Name (First, Middle, Last) Alice Eleanor Smit	n				2. Date of I Month Septer	Death Da		3. Time of	Death A M
ĵ.	Examir		4a. Facility Name (If not institution, give s Cherry Hill Assist			4b. City, Town Accider		f Death		County of D		
	Funeral Director		5. Social Security Number 6. Sex 218-50-0755	7. Age (In yrs. last birthday 91 Yrs.) If Under 1 Yea Months Day		Min. 8. Date of E (Month, Aug.	irth Day, Year L	.914 Ma	Birthplace (State of Country) ryland	r Foreign
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	ath with the 23a or 21		110 S. South Stree			10f. Zip Code 2152	0		USA	itizen of What	Country?	
2-0030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mantal Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-4 show any injury or other traumatic event, Ita Medical Evantius from the notified a onze.	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Even Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates:	er in U.S. 13.	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🛣 N		in? (Specify Yes or f Puerto Rican, etc.)	10-	Black, W	merican Indian, hite, etc. Vhite	
1-61717	d within 72 h giene. or than "natu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation com <i>pleted)</i> College (1-4or 5+)	(Give	dent's Usual Occ e kind of work don DO NOT use retii	upation le during most red)	of working		ind of Busine	ss/Industry	
yiand	iould be file Mental Hygnarked other natic event,	To Be C	17. Father's Name (First, Middle, Last) Edward Deal				Emma	's Name (First, Midd Durst				
e, Mai	1 and 2 sh Health and Health and Her traun		James A. Smith/Son 20a. Method of Disposition			Box 9, A		or Rural Route Num	nd 2]	L520		
Daitimor	it. Pages rtment of i rtant: If its njury or o		1 Burial 2 Cremation 3 Re '4 Donation 5 Other (Specify)	emoval from State	Zion Cem	matory or other pi etery	Se	ept. 5,200	5 A	cciden		
מ	Depar Impor any ir		21. Signature of Fungral Service Licenses 21. Signature of Fungral Service Licenses 22. Signature of Fungral Service Licenses	ma	. Р	.O. Box	275, G	Newman Fu rantsville	, Ma		21536	
	Physician (Medical Examiner physician and ph	al Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	onsequence of):	enturion AD	failnye	arulac or respiratory	arrest,		Approximate Interval Betwood Donset and D	veen
O. DOX 00	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours attend death. The Atnoreal Director: Attenthis certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	ic. If yes, outcome of a 1 Live birth 2 Live birth 2 Live Dregnant at tim	Fetal death 3	Ectopic pregnan	су			23d. Date of d Month		ear
orus, r	quires that n signed b uid be deta	by	Part II. Other significant conditions conf	ributing to death but n	not resulting in the u	nderlying cause g	iven in Part I.		tobacco u	1.00	to the cause of de	
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200	ttending l death. ctor: After y the funer	Certification;	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Ye		M 1 []Yes 2 □ No					
2	To the Hospital or Attending Is within 24 hours after death. To the Funeral Director: After completely filled in by the funer		4 Homicide determined 29a. Certifier 15 Certifying Physic	cian: To the best of m	Specify)	Occurred at the t	time date and	City or To	wn, State)	Rural Route Numb	97,
	To the Ho within 24 To the Fu completely	Medical	(Check only one) 2 Medical Examination Medical Med	er: On the basis of example and manner stated	amination and/or in	vestigation, in my	opinion, death	occurred at the time	date and	place, and du	ne to the cause(s)	
			30. Name and address of person who con	npleted cause of death	h (Item 23a) (Type	Print)	4200	04.	9.	1-0	5	
	Sta	te	231 Ord St, 31. Date filed (Month, Day, Year)	Salisb 32. Redistrar's	ury, Px	A. 155	58. -	Dr. Shaw	n Bel	.1		
	Registr	ar	SEP - 2 20	105	and the de	South						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year Physician 28, Gloria Dianne Snyder August 2005 9:07 A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 10412 Carlyn Ridge Road Damascus Montgomery Damascus

If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

Months | Days | Hours | Min. | Feb. 24, 1953 9. Birthplace (State or Foreign Country) Mary Land 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 📆 F 52 Yrs. 214-60-6115 Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a State in than "natural", or iteme 23a or 28a-f show Yes 2 □ No Maryland Montgomery Damascus Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10412 Carlyn Ridge Road 20872 U.S.A. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 1 No
If Yes, Give
Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: δ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health end Mental Hygiene. ant: If Item 27 is marked other than 'ury or other traumatic event, Item Ma College (1-4or 5+) Elementary/Secondary (0-12) 12 Warranty Administrator Automobile 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Schmidt Gloria Ourand Pau1 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert L. Snyder -Husband 20872 10412 Carlyn Ridge Road, Damascus, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Demation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. All Souls Cemetery Sept. 1, 2005 Germantown, Maryland 21. Signature of Funeral Service Licenses 01in L. Molesworth P.A., Funeral Home overt 20872 26401 Ridge Road, Damascus, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ane realic Immediate Cause (Final METASTATIO 9 months **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? Day 5 Other (specify) 4☐Pregnant at time of death ed by the a 9 Unknown 9 Unknown ete has been signed I page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
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2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier CIM D August 29, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11065 Little Patuxent Parkway, Columbia, Nicholas W. Koutrelakos, M.D. 32. Registrar's Signature State Collins . AUG 3 U ZUUU Registrar

Debra Jean Spangler 05-06011 NJM -

Amended Item 4a per M.E. 09/07/2005 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Unpend Item Registrar	State of Marylar 23a,27,28a-f	nd/Depa per <u>me</u>	artment C847 rtificate	of Heal 9-14-0 of Dea	th and I 15, tas ath	Mental Hy	giene Reg. No.	2005	29638
	Dhusisi		1. Decedent's Name (First, Middle, Las	1)		-			2. Date of De		o Year-	3. Time of Death
	Physici /Medic		Debra J. B. S	Spangler					Septemb	er .	3 2005	0303 м
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, To	own, or Loca	tion of Death	1	4c. (County of Death	
	·		4715 Barhed Cour	t-			stead	- 1 04 1			Carroll	
	Funeral		5. Social Security Number 6. Se	□M 2QF	last birthday) Yrs.	If Under 1 Months		nder 24 Hrs. urs Min.	(Month, Da	y, Year)	9. Birth	place (State or Foreign intry)
	Director		578-88-2507 Usual Residence of Decedent	A 46					Jan 3,	1959	Ore	egon
	land		10a. State 10b. County	10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
	Mary	to	Maryland Carro	L1 H	ampste	ad						1 XYes 2 ☐ No
	r 28e	Director	10e. Street and Number			10f. Zip C	ode		1	10g. Citiz	en of What Cou	intry?
	h with		4715 Barbed Ct.			2	21074			USA	A	
	deet	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. \	Was Decede	nt of Hispani	ic Origin? (S	pecify Yes or No o Rican, etc.)	- 1	4. Race - Ameri Black, White	
ور	or Ite	Fu	1 Never Married 2 Marned	1 ☐ Yes 2 1 No		1 □ Yes 25		ecify:	o 11.0dii, 0.0.,		Specify:	, 616.
8	within 72 hours after deeth with the Maryland ene. Han "natural", or Iteme 23a or 28e-f ehow he Madical Examiner must be notified at	d by	3 ☐ Widowed ♣️∰Divorced	Year or Dates:							Wr	nite
Maryland 21215-0036	72 h	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Deced	dent's Usual kind of work DO NOT use	Occupation done during	most of wor	king		d of Business/Ir	
2	withing the n	mp	Elementary/Secondary (0-12)	College (1-4or 5+)							coll Hos	spital
N D	filed withi Hygiene. other than	ပိ	12 17. Father's Name (First, Middle, Last)	4	Reg1	stered			ne (First, Middle,		enter	
a	ould be I Mentel I arked o etic eve	Be c	Wayne Bixel					Carol			,	
<u>></u>	should Ind Men	2	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailin	ng Address (1		ral Route Numbe	er, City or	Town, State, Zi	p Code)
S	ges 1 end 2 should be filed within 72 hours after deeth with the Marylan it of Health and Mentel Hygiene. It of Health and Mentel Hygiene. It of Health and Mentel Uther Itan That is marked other Itan That That That That That Itan Itan Itan Itan Itan Itan Itan It		Briana Spangler	Daughter	4715	Barbec	l Ct.	Hamps	stead, M	D 21	.074	
ē,	ten ten othe		20a. Method of Disposition	1 /	Place of Dispo	sition (Name	of er place)		Date	20c. Loc	ation - City or T	own, State
Ę	Page lent o nt: If ry or		1 ABurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	rgreen	-		ns 9/	′8/05	Finks	burg, M	Maryland
Baltimore,	permit. Pages 1 end 2 Depertment of Health a Important: If Item 27 le eny injury or other tre once.		21. Signature of Funeral Service Licen						tte Fun	oral	Home C	Chapel, PA
m	89 E 8		I John K Ag	5		12 Was	shinata	on Rd.	Westmi	nster	MD 2	21157
			23a. Part . Enter the disease, or comp shock, or heart failure. List only	lications that caused the deat								Approximate Interval Between
ı	Physician		Immediate Cause (Final disease or condition	a Mixed drug (Ouetia	nine a	nd Pro	oprano	1o1) int	oxic	ation	Onset and Death
	/Medical		resulting in death)	Due to (or as a conseq		pine c		JP1 4411				
	Examiner		Sequentially list conditions,	b								
	sit ad	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):							
	and and I-tran	хаш	that initiated events resulting in death) Last	c. Due to (or as a conseq	mence of):							
8760,	The law requires thet the death certificate be executed site has been signed by the attending physicien and page 2 should be deteched for use as the burial-transit	E E		200 10 (0. 20 2 00.100)	3.7.							
387	physicate physics the	dlcal	•	d								
9 X	death certifica attending pl	/Me	IF FEMALE:	23c. If yes, outcome of pregna						23	3d. Date of deliv	erv
Вох	eath atter I for u	clar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		Ectopic pred Other (spec					Month	Day Year
o.	thet the de led by the a deteched i	Physician/Me	9 Unknown	9□ Unknown								
.	res thet Igned b be det	by P	Part II, Other significant conditions of	ontributing to death but not res	ulting in the ur	nderlying cau	ise given in F	Part I.	23e. Did to	obacco us	e contribute to t	the cause of death?
ğ	w require been slg should b								10	∕es 2□	No 3 ☐ Prol	bably 4 Unknown
ပ္ပ	s bee	Completed							24a. Was		24b. Were auto	opsy findings available
æ	The lav	E							autor perfo	rmed?	death?	empletion of cause of
<u>r</u>		Bec	25. Was case referred to medical examiner?				26. f	Place of Dea	th (Check only o			
<u>></u>	ysic nis ce I dire	2	1 XYes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 DOA	Other: 4[☐ Nursing H	ome 5 ☐ Resid	dence 6	Other (Specia	(v) Scene
0	Attending Physicien: r death. ector: After this certific by the funeral director.		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury 9-3 ^M 05 Day Year)	28b. Time of 3:00	280	:. Injury at Work?		28d. Describe	now injury	occurred	
Division of Vital Records,	uttendi death. ctor: A y the fu	catl	2 Accident investigation	found	found	a M		2 X No	subject			
≦	i or At efter d Direct I in by	Certification:	3 Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	om e, far m, stre y)	eet, factory,	office		28f. Location (S City or Tox	Street and vn, State)	4715 Ba	rbed Court
	ospitei hours e unerei E ly filled		29a. Certifier 1 ☐ Certifying Phy	found at hou			the time day		Hampstea			
	12 T S	Medical	(Check only 2 Medical Exam	/sician: To the best of my kno iner: On the basis of examina and manner stated.	ition and/or inv	vestigation, in	my opinion,	, death occu	rred at the time,	date and p	lace, and due t	o the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	1 1		29c. l	License num	ber		29d. Date	signed (Month,	Day, Year)
) IN	11.11			OCME			Sente	ember, 3	3. 2005
	MIL		30. Name and address of person who d	completed cause of death (Item	n 23a) (Type.		JULIU			Septe		, 2005
	1		1 -	M Titus M.	D.		Penn	Street	Balti	more,	, Maryla	and 21201
	-	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature							

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** August 22, 2005 4:40 P Settingiano Luigina /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Annapolis
If Under 1 Year I If Under 24 Hrs. Anne Arundel Anne Arundel Medical Center 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 💢 F Yrs. Director 7-15-1920 Italy 85 579-42-1044 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other then "naturel", or items 23s or 28s-f show other treumstic event, the Mudical Examination is indiffied at 1 ☐ Yes 2√2 No Director Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 21401 1968 Marconi Circle USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filled within 72 hours after to Department of Health and Mental Hygiene. If item 27 ie marked other then "natureit, or itemeny injury or other treumetic event, the Medical Examina-1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clothing Stores 5th Seamstress 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Salvatore Settingiano Assunta Basile 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lawrence J. Filippelli/ Cousin 364 Lankford Rd., Harwood, MD 20776 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 XOther (Specify) Entombment Resurrection Cemetery 8-29-05 Clinton, MD 21. Signature of Funeral Septice, Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lipe. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and Due to (or as a consequence of): the ettending physicien a hed for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2/2 1 ☐ Yes 2 ☐ No 1 ☐ Yes i or Attending Physician: after death. Director: After this certifice 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Impatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital of within 24 hours all To the Funerel D completely (illed in 295 Cortiflar Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and State Registrar

			. For	partment of Health and Mertificate of Death	lental Hygie	000	
			Hegistrer 1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Marjory E. Sayers		Aug.	20, 2005	0800 M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			206 McKinsey Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Severna Park			Arundel place (State or Foreign
	Funeral Director		066-05-3411 1□ M 2□XF 90 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Apr. 26,	1915 Mont	real, Canad
	land ow		Usual Résidence of Decedent 10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Mary a-f sh	tor	MD Anne Arundel	Severna Park			1 ☐ Yes 2 ☑ No
	or 284	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cou	intry?
	s 23a		206 Mckinsey Road 11 Marital Status 12. Was Decedent Ever in U.S. 13	21146 B. Was Decedent of Hispanic Origin? (Spe	poitu Vas or No-	USA 14. Race - Amer	ican Indian
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other then "neturel", or items 23a or 28a-f show or other fraumatic event, if a Medical Exant. In fourtied at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 ☆ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	
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2	filed with Hygiene. other ther ent, tran		12 17. Father's Name (First, Middle, Last)	Homemaker 18. Mother's Name	e (First, Middle, Ma.	Home iden Sumame)	9
auc	ld be fental 1 ked o	To Be	Albert R. Elvins	Olive 1	Edna Benn	ett	
ary	2 should be f and Mental I Is marked or raumatic eve	-		iling Address (Street and Number or Rura		-	p Code)
Z	1 and 2 Health a lem 27 ts			6 McKinsey Road, Se			146
altimore,	Pages 1 nent of H nt: If ite		1 Neurial 2 Cremation 3 Removal from State	romaton, or other alocal	24	c. Location - City or T Hagerstown	
Balti	permit. Pages 1 and Department of Health Importent: If item 27 eny injury or other t 20029.		21. Signature of Juneral Service Licensee	22. Name and Address of Facility P. 23 195 Gov. ritchie Hw	A. Severn	a Park Fu a Park, M	neral Home 21146
	Pnysician		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition	P-1	or respiratory arrest		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a Due to (or as a consequence of).	,	1.0		S MCMIN
n	Examiner		Sequentially list conditions. b. Chronic O	osTructive Pulma	mary Di	Senre	1 Cars
	led sit	nlne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
Ć,	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last c. Due to (or as a consequence of):				
8760,	ite be iysicia ne bur	dlcal	d.				
9	entifica ling ph e as th	Med	IF FEMALE: 23c. If yes, outcome of pregnancy				
Box	death certific e attending p od for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1	B Ectopic pregnancy Dither (specify)		23d. Date of delin	Day Year
P.0.	that the de ed by the detached	hys	9 ☐ Unknown				
Ś	Se G	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	1 Tes	2 ₩No 3 □ Pro	the cause of death?
Record	e taw has b je 2 si	Completed			24a. Was an autopsy performe	prior to o	opsy findings available ompletion of cause of
Vital	icien: Th certificate ector, paç	BeC	25. Was case referred to medical examiner?	10 11 10 10	(Check only one)		
of V	Physicien: r this certific ral director,	P	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpai 27. Manner Death 28a. Date of Injury 28b. Time		me 5 Residence 28d. Describe how		rfy)
on (ding I h. After funer	tlon	1 Matural 5 Pending (Month, Day Year) Injur		200. 2030/20 110#	injury cocorrod	
Division	l or Attending after death. Director: Afte I in by the fune	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical Ce	29a. Certifier (Check only one) 29a. Certifier (Check only one) 2 Medicel Exeminer: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place, investigation, in my opinion, death occurred	and due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	29c. License number	29d	Date signed (Month	. Day, Year)
•			30. Name and address of person who completed cause of death (Item 23a) (Tyr			01/ /-	•
			Joseph Friend 116 Det	ense they By	ingolis) WM	21401
	St Regist	ate rar	31. Date filed (Mork) Day, Year) AUG 2 4 2005 32. Restrar's Signature	Speck	J		

DHMH 17 Rev 1/2001

ORIGINAL

David Snyder 05-05648 RPD

			For State	State of	Maryland / D		artment of Hertificate of D		ind M		giene Reg. No. 2	005	29641
			Registrar 1. Decedent's Name (First, Middle,	Last)						2. Date of Dea	ath		3. Time of Death
	Physicia		David		Sny	de	c			August	20, 2	2005	2310 P ^M
	/Medic Examin		4a. Facility Name (If not institution,	give street and numb	per)		4b. City, Town, or	Location o	f Death			nty of Deatl	
	_Admi.	•	University Hosp	ital			Baltimore	ة					
	Funeral			6. Sex 7. 1 XM 2 ☐ F	. Age (In yrs. last birt		If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da July 9,	h v. Year)	Co	nplace (State or Foreign untry)
	Director		213-25-2630	1224 2	16	Yrs.				July 9,	1989	Mar	yland
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Lo	cation						10d. Inside City Limits
	Mary fehc	ğ	MD Anne A	rundel	Arno	1d							1 ☐ Yes 2X No
	r 28a	rec	10e. Street and Number				10f. Zip Code				10g. Citizen	of What Co	untry?
	h witi	a D	696 Kinderhaven	Road			210	012				USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelih and Mental Hyglene. Important: if item 27 is marked other then "natural", or iteme 23a or 28a-f show supprigning or other traumatic event, the Madical Examinar must be multiled at an once.	by Funeral Director	11. Marital Status XXNever Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deced Armed Force ad 1 Tyes 2 If Yes, Give Year or Dat	es? XXNo	1	Was Decedent of His If Yes, specify Cubar I ☐ Yes 2 \$\textsquare No	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)		Race - Ame Black, White acify:	ncan Indian, e, etc. White
8	tural	ed	15, Decedent	s Education		Dece	dent's Usual Occupa	ition		1	16b. Kind o	f Business/	Industry
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212	d with	Completed	9	Comego (1	St	ude	ent				E	lucati	Lon
Maryland 21215-0036	at Hy	Be	17. Father's Name (First, Middle, L	.ast)						(First, Middle,	Maiden Sun	name)	
yla	Ment Ment arked	2	Larry Snyder							tton			
Nar	2 sh and is m		19a. Informant's Name/Relationsh Larry Snyder (I				ng Address <i>(Street</i> a K inderhav (up Code)
e, r	1 and 1eelth 1m 27 ther t		20a. Method of Disposition	acher			esition (Name of	en ko		ate			Town, State
Baltimore,	or of		1 X Burial 2 ☐ Cremation		tate cemeter	y, crei	natory or other place		22	2005		olis	
턆	artme ortani Injury		4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L		HILLCI		t Cemeter			-		OTIS	FID
Ba	Dermi Depe Impo eny ir		· Batarl	4 Weld	//(Name and Addres Hardesty 12 Ridge	Fune ly Av	raı enue	, Annar	olis,	MD 21	1401
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that ca	used the death. Do r	not ent			_				Approximate Interval Between
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	/Medical		resulting in death)	Due to (o	r as a consequence	of):				- (
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	ate be executed thysicien and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (o	r as a consequence	of):						-	
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687	ficate p physics is the	edic		0.							-		
.O. Box	that the death certificate be executed ed by the ettending physicien and detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live bir	ome of pregnancy th 2 Fetal death nt at time of death wn		Ectopic pregnancy Other (specify)				23d.	Date of del Month	ivery Day Year
Q	The law requires that the ste best signed by the bage 2 should be detache	by Pt	Part II. Other significant condition	ns contributing to dea	ath but not resulting in	n the u	nderlying cause give	en in Part I.		23e. Did t	obacco use	contribute to	the cause of death?
rds	quires n signe uld be									10,	res 2/1 N	o 3 □ Pr	obably 4 Unknown
Vital Records,	aw require is been si 2 should t	Completed								24a. Was		b. Were au	itopsy findings available completion of cause of
R	The It	E					-			perfo	rmed?	death?	2 No
ital		BeC	25. Was case referred to medical examiner?					26. Place	of Death	(Check only o		/>	
	d is	2	1 X Yes 2 No			_	nt 3□ DOA Othe	4 140	irsing Ho	me 5□Resi	dence 6 🗆	Other (Spe	cify)
n of	D 39 0	ü	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of		Time o	Work		. 1	28d. Describe	now injury od	curred	- saus
sio	Attending r death.	cat	2 Accident investig 3 ☐ Suicide 6 ☐ Could r	ot be	of Injury - At home, fa	5	3 M 10	Yes 2	<u> </u>	29f Location (Street and N	Jumper or A	ural Route Number,
Division	tel or Attendits safter death.	Certification:	4 Homicide determi	ined buildin	g, etc. (Specify)	3/	Massar Mariory, office			City or To	vn. State	. //	tening les
	Hospital		29a. Certifier 1 ☐ Certifyin	g Physician: To the I	best of my knowledge	e, deat	h occurred at the tim	ne, date an	d place,	and due to the	cause(s) and	manger as	stated.
	• Ho: • Fur letely	Medical	(Check only 21 Medical one)	Examiner: On the ba	sis of examination an er stated.	d/or in	ivestigation, in my or	pinion, dea	th occurr	ed at the time,	date and pla	ce, and due	to the gause(s)
	To the Hospital or A within 24 hours after To the Funeral Direct Completely filled in D	Me	29b. Sign sture and title of certifier	0	\cap		29c. License				29d. Date si	gned (Mont	h, Day, Year)
)			tor	te W			0.C.P	1.E.			August	21,	2005
			30. Name and address of person	who completed cause	of death (Item 23a)							01.00	
			31. Date filed (Month, Day, Year)	32	egistrar's Signature	_P∈	enn Street	., Ba.	Ltimo	ore, Ma	ryland	2120	Τ
	Sta Regist		AUG 2 4	2005	Aug K	A	noth)						
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State of Maryland / Department of Health and Mental Hygiene For State Registra 29642 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 08 **Physician** 9:15 A M 30 SHRODES JEAN Isabel 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARFORD MARINER HEALTH OF FOREST HILL FOREST HILL If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day Year)
March 10, 1920 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Min. Hours Months Days Maryland 1 □ M 2 🕅 F 85 216-38-6943 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ui Hygiene. I other than "natural", or items 23a or 28a-f ehow vent, the Medical Exprinter rities to indiffical at 1 ☐ Yes 2X No Director White Hall MD Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21161 U.S.A. 5014 Carea Road Funerai filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 XNo If Yes, Give 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: If Yes, Givo Year or Dates: þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Realtor Self employed 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other treumatic event 2008. Be Pearl Jenkins Roy McElwain 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5013 Carea Rd., Pylesville, MD 21132 David W. Shrodes/son 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Sept. 1 🎇 Burial 2 □ Cremation 3 💆 Removal from State Centre Presbyterian New Park, PA Cemetery 2005 * 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. of Ineral 21. Signalu 19 South Main St., Stewartstown, PA 17363 Approximate Interval Between Onset and Death the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, art failure. List only one cause on each line. k, or he Immediate Cayse (Final disease or condition Physician superin resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Due to (or as a consequence of) Examiner burial-transit Cause (Disease or injur) that initiated events attending physicien and resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medicai as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No detached the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director. Be examiner? Other: Nursing Home 5 Residence 6 Other (Specify) 25 No 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 2 No М 1 Yes To the Hospital or Attendii within 24 hours after death. To the Funerel Director: A investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 🔁 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier AUIU5-30, 200 032255 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. DAVID DUNN, 615 W. MACPHAIL ROAD, BEL AIR, MARYLAND 21014 31. Date filed (Month, Day, Year) State SEP 0 9 2005 Registrar

	1	State of Maryland / Depa	artment of Health and Mer	ntal Hygier Reg. I	2005	29643
Physicia		1. Decedent's Name (First, Middle, Last)	2.	Date of Death Month	27 2005	3. Time of Death
/Medica	al -	William Carl Stanley, Sr. Ta. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		27 2005 4c. County of Death	1554P ^M
Examine	er	Memorial Hospital	Easton		Talbot	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8	Date of Birth (Month, Day, Yea	9. Birthol	ace (State or Foreign
Director		222-18-7182 1AM 2□F 75 Yrs.	Nomina Baya Trodia William	10/25/	29 Del	aware
land ow	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation		10	Od. Inside City Limits
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ith the Marylar or 28a-f show	Sirec	10e. Street and Number	10f. Zip Code		Citizen of What Coun	try?
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	by Funeral Director	1 Nover Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ric 1 ☐ Yes 2 X No Specify:	an, etc.)	Black, White,	
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led wi tygien har th		17. Father's Name (First, Middle, Last)	CK Driver 18. Mother's Name (F			.13
Idito	To Be	Lee W. Stanley, Sr.	urma		01	
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water per executed with price of the purial-transit the burial-transit the burial-transit the purial-transit	Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	Embousm			Interval Between Onset and Death
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death certific	Physician/Medi		⊒Ectopic pregnancy □ Dther (<i>specify</i>)		23d. Date of delive Month	ry Day Year
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COLDS, P. w. requires that s been signed t should be detailed.	ted	17-HERD SCURROTIL CARDIOVASCU	UR DIGHTE	1 ☐ Yes	2 No 3 Prob	ably 4 Munknown
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DIVISIO To the Hospital or Attendit within 24 hours after death. To the Funaral Director: A completely filled in by the fu	edicai (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.				
To the within 2 To the complet	Me	29b. Signature ago the of contribution MID - ATTENDING	29c, License number 5094	29d.	Date signed (Month, I	Oay, Year)
		and ad ress of person who completed cause of death (Item 23a) (Type,	BLOOMING ACE DU	re Verm	Asses, /	ND'
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	(and			

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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - State AMEND#13, perFH8/25/05, DPS, MoCo 29644 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2005 Year **Physician** 3:35 A.M Errett Straley August 22 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gaithersburg Montgomery Wilson Health Care Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Hours | Min. | April 12, 9. Birthplace (State or Foreign Country) North Carolina 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1₽M 2□F Yrs 239-18-3231 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "neturel", or items 23e or 28a-f show any injury or other treumatic event, the Medicul Examinar must be rediffied at ODE. 10c. City, Town or Location Gaithersburg 10d. Inside City Limits 10b. County Maryland Montgomery 1 XYes 2 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 301 Russell Avenue United States 20877 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 Specify: White Tes 2 No Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrative Officer U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lorene Culler Errett Straley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 407 Russell Avenue #612, Gaithersburg, MD 20877 Dorothy J. Straley/ Wife 20b. Place of Disposition (Name of commeter), crematory of other place):

Geo. Wash. University August 23
Medical Center 2005 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. * 4 Donation 5 ☐ Other (Specify) 2 Signature Funera Service Licensee 22. Name and Address of Facility Columbia Mortuary Services, Inc. P.O. Box 58007 Washington, D.C. 20037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ilure to Mrine Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner phage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to or as consequence Examiner in in arction attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Lypertension 1 □ Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Lyperle 2 No Yes 25. Was case referred to med I examiner? Division of Vital To the Hospitel or Attending Physicien: 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Manuer of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation М 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 200 4 ingust 22, 2005 104115 VI Poher & Brechbach Will 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 RUSSELL AVENIZE GAITHERSBURG, MID 20897 1+ROBERTBIRSCHBACH, MD. 31. Date filed (Month, Day, Year) AUG 25 32. Segistrar's Signature Coarte 2005 Registrar

DHMH 17 Rev 1/2001

Elma Taylor August 19, 2005 at 10: 42

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legib
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			For	State of Mary	yland / Depa	artment of H	ealth and I		•	E 00616
			State Registrar		Cei	rtificate of L	Death			
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	/Medic	al	Elma 4a. Facility Name (If not institution, g		ylor	4b. City, Town, or	Location of Deat		19, 2005 4c. County of Dea	10:45 AM
	Examin	er			m o	Princess		1	Somerset	u i
	Funeral		Manokin Mano 5. Social Security Number 6.	Sex _ 7. Age (II	n yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.		9. Bir	thplace (State or Foreign
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Dailmore, M permit Pagas 1 and 2 Departmant of Health	itam		20a. Method of Disposition	. 77	1 00	ace of Dispo	sition (Name o	f place)	Da	ate	20c. Location	n - City or To	own, State
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		(20a. Part1. Enter the disease, or shock, or heart failure. List of	complications that cau only one cause on eac	ised the death. th line.	. Do not ent	er the mode of	dying, such as	s cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
	sician		Immediate Cause (Final disease or condition resulting in death)	a	- 000	non	y A	~ der	4 6	Duseo	2		19 y-s
	edical miner		resulting in deadily	Due to (or	as a consequ	ence of):	/		1				
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petr	ansit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	<	31-		20	2am	SF	in l	201		2205
axacı	an and rial-tra	Еха	resulting in death) Last	Due to (or	as a consequ	ence of):							7.2
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that the	ad by detac		Part II. Other significant condition	ns contributing to dea	th but not resu	Iting in the u	nderlying cause	given in Part	l.	23e. Did to	bacco use co	ontribute to t	he cause of death?
Ords,	d be	d by	1242m2	~ » · ~	_					1 🗆 Y	′es 2⊡+nó	3☐ Prot	bably 4 Unknown
ecords law raquires	baer	lete								24a. Was	an 24t	o. Were auto	opsy findings available
The law	ate has paga 2	Completed				· · · - · - ·				autop	med?	prior to co death? 1 Yes	mpletion of cause of
VITAI	s certificate has b lirector, paga 2 s	e C	25. Was case referred to medical					26. Plac	e of Death	1 ☐ Yes (Check only o	2 3 No	T Tes	2 🗆 140
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T OF	After this funeral di	T:uc	27. Manner Death 1 atural 5 Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of	28c. I	njury at Work?	2	8d. Describe h	ow injury occ	urred	
andir sath.	tor: After this certific the funeral director,	atle	2 ☐ Accident investig	ation			М	1 □ Yes 2 □	-				
DIVISION or Attanding after death.	iract n by 1	ertification;	3 Suicide 6 Could n 4 Homicide determi	ned 266. Flace of	f Injury - At hor , etc. <i>(Specify</i>	me, farm, str ')	eet, factory, off	ice	2	8f. Location (S City or Tow	itreet and Nui m, State)	mber or Rura	al Route Number,
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o th	Co the	Me	29b. Signature and title of certifier				29c. Lic	ense number			29d. Date sign	ned (Month,	Day, Year)
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Exam	iner	4a. Facility Name (If not ins Genesis	_			- k	-	napo		or Death			ne Aru		
Funera	al	5. Social Security Number	6. Sex	7.	Age (In yrs.		If Under Months	1 Year	If Under Hours	24 Hrs. Min.	8. Date of Birth		a Righ	place (State o	r Foreign
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ifter d ir Iten	Fun	1 Never Married 2		Armed Force 1 X Wes 2 If Yes, Give	es?	1					ecify Yes or No- Rican, etc.)	Ì	Black, White		
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To the He within 24 To the Fu	₩	29b. Signature and title of	certifier	221		****	290	. License	number		2			, Day, Year)	
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	State	31. Date filed (Month, Day		/!	istrar's Signa		4	000	ww.		1 0 4011	- (- 13)			
Regi			24 2		ton.		March 1								

State of Maryland / Department of Health and Mental Hygiene 2005 29649 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 3:00 A-M SARAH M. VENZA 04 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SNERED HEART HOSDITAL CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🕱 F 155-40-7909 95 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-1 show traumatic avant, the Modical Examiner must be notified at 1 XYes 2 No N.I BURLINGTON SOUTHAMPTON TOWNSHIP Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 12 MARLBOROUGH DRIVE or Itams 23a 08088 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: À Specify. 3 Nidowed 4 Divorced WHITE Year or Dates: "natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) s 1 and 2 should be filed within 7 f Haalth and Mental Hygiene. Itam 27 la markad othar than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 EXECUTIVE SECRETARY EDUCATION 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be NICOLA SCHIAVETTA ANTIONETTA NATARO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 204 SUNSET DRIVE, LAVALE, MD 21502 J. RICHARD VENZA/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of Ha
Important: If itar
any injury or oth 1 Burial 2 Cremation 3 Removal from State SACRED HEART CEMETERY 9-9-2005 HAINESPORT, NJ * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SCARPELLI FUNERAL HOME, 21. Signature A Fineral Service Licensee 108 VIRGINIA AVE., CUMBERLAND, MD 21502 Approximate Interval Between Onset and Death 23a. Part 2. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stack, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition sepsis 7 days Physician Synchrone disease or condition resulting in death) /Medical Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Jussass or injury that initiated events Due to (or as a consequence of): Examiner certificate be executed as the burial-transit resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signad by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ξ should be artery Coronany 1 Yes 2 No 3 Probably 4 Tunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 Yes 2 X No Division of Vital or Attanding Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Anpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide tha Hospital 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier wowood shi po055325 Sep 04, 2005 O 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frosthung MD WONSOCK 78 Tarn SHIN Terrace 31. Date filed (Month, Day, Year) SEP 0 9 32! Registrar's Signature State 0 9 2005 Comples House Registrar

Vaurice Wood 220-01-5418

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Maurice Wood /Medical Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Regional Center Vicamic Peninsula Dajsher 7. Age (In yrs. last birthday) If Under 24 **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) M 2 F Days Min Director 220-01-5418 85 08/26/1919 <u>Maryland</u> Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location : if item 27 is marked other than "natural", or itams 23a or 28e-f ehow or other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Yes 2 No MD Worcester Pocomoke City Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1018 Lynnhaven Drive 21851 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White etc. 1 XYes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 12 should be filed within 7. h and Mental Hygiene. 7 is marked other than "nu (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) none Inspector <u>Housing</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ashby Wood Gertrude Murr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and important: if itam 27 is n any injury or other traur Lawrence Wood/Son 33726 Dublin Road, Princess Anne, MD 21853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory | 08/27/2005 | Salisbury, Maryland 22. Name and Address of Facility
Hinman Funeral Home 3a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Interval Between Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ardiomu disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury monar Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate Division of Vital 1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospitei or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After th 28a. Date of Injury (Month, Day 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funaral Director: completely filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature 29c. License number

Registrar
DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

AUG 2 9 2005

dress of person who completed cause of death (Item 23a) (Type, Finit) Steven Hamlette (20 E.

32. Registrar's Signature

1)0060225

			1 - For State Registrar	State of	Maryland / Dep <i>Ce</i>	artment of F	lealth and <i>Death</i>		giene 0	05	29651
	Physici	an	1. Decedent's Name (First, Middle	e, Last)				2. Date of Dea Month	ith Day	Year	3. Time of Death
	/Medic		Edwin Henry W			45 Oh T-	at Santa Amil	- cargare	27, 200		11:54 a ^M
}	Examin	er	4a. Facility Name (If not institution				or Location of Dear	th	4c. County		
	F		Bonds Forest As 5. Social Security Number		lng . Age (In yrs. last birthday	Finksh	If Under 24 Hrs			9. Birthpia	ace (State or Foreign
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	D		Usual Residence of Decedent								
	arylar show	7	10a. State 10b. County		10c. City, Town or L					10	0d. Inside City Limits 1 ☐ Yes 2X No
	he M	ecto	Maryland Carro	11	Fink	sburg 10f. Zip Code	-		10g. Citizen of \	What Count	
	with	Funeral Director	2261 Old Westm	ington Dile	_	210	240		-	What Count	.,.
	ns 23	era	11. Marital Status	12. Was Deced	ent Ever in U.S. 13.	Was Decedent of H	Hispanic Origin? (9	Specify Yes or No-		ce - America	
ധ	or itar	Fur	1 Never Married 2 Marr	Armed Force ied 1 Tyes 2 If Yes, Give		If Yes, specify Cub 1 ☐ Yes 2 XNo		to Rican, etc.)		ck, White, e	tc.
Ö	ral', c	d by	3 XWidowed 4 ☐ Divorced	Year or Date	es: 1945	10 105 212140	эрөспу.		Specify	Whi	
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	e filed within al Hygiene. I othar than "vent, the Mark		17. Father's Name (First, Middle,		IIISUL	ance Brok	18. Mother's Na	me (First, Middle,	Maiden Suman	_wilib	eris & Co.
Maryland		To Be	Edwin Henry	Wimperis, S	Sr.		E	lizabeth	Stephen	ıs	
ary	2 should and Meni is marka		19a. Informant's Name/Relations	hip (Type, Print)	1	ing Address (Street			-	State, Zip	Code)
	s 1 and 2 of Health a item 27 is othar trau		William J. Wimp	eris (son.	Carzil I	or. Fink	sburg, M			
altimore,	of He		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation		20b. Place of Disp	osition (Name of imatory or other pla	сө)	Date	20c. Location -	· City or Tov	vn, State
Ë	Pag tment tant:		`4 □Donation 5 □ Other (S		Hopewell Hopewell	Reformed	Ch. 8/	31/2005	Hopewel	1 Juna	ction, NY
Bal	permit. Pages Department of I Important: If ite any injury or of		21. Signature of Funeral Service	Licensee	2	2. Name and Addre	ess of Facility	tts Fune	ral Hom	e & C	hapel, PA
			23a. Part1. Enter the disease, or	complications that cal	sed the death. Do not en	12 Washir					157 Approximate
	71		shock, or heart failure. List Immediate Cause (Final	only one cause or ea	th line.	I (71				Interval Between Onset and Death
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	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of death 5	Other (specify)	у		Mo	onth [Day Year
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oro	law requires as been sign 2 should be	eted							1		
Vital Records,	e – e	Completed						24a. Was a autop perfor	med?	prior to com death?	sy findings available apletion of cause of
a		e Co	25. Was case referred to medica	1			26 Place of Do	1 ☐ Yes eath (Check only or		1 ☐ Yes 2	2 E N o
>	Physician: rthis certific ral diractor,	O B	examiner? 1 ☐ Yes 2 ☐ No	Haspital:	patient 2 ER/Outpatie	ent 3 DOA Ott	205	Home 5 Resid	1	ier (Specify)	ASSISTED
J Of	tending Physician: leath. tor: After this certific the funeral diractor,	n: T	27. Manner of Death 1 Natural 5 Pendir	28a. Date of	Injury 28b. Time			28d. Describe h			LIVING
iois	endin sath. or: Af he fur	atic	2 Accident investi	gation			Yes 2□No				
Division	or Attending I after death. Director: After In by the funer	ertification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 28e. Place of building	f Injury - At home, farm, s g, etc. (Specify)	treet, factory, office		28f. Location (S City or Tow		er or Rural	Route Number,
	pital o	O	29a. Certifier 1 Certifyii	a Physician: To the h	est of my knowledge, dea	th assured at the ti	mo data and also	a and due to the	aguag(a) and ma	2005 20 01	stad
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	(Check only 2 Medical	Examiner: On the bas	is of examination and/or i	nvestigation, in my	me, date and place opinion, death occ	urred at the time, o	tate and place,	and due to	the cause(s)
	ro the vithin ro the comple	Me	29b. Signature and title of certifie	· 1/ A	1 1 1 0	29c. Licens	se number	. 0	29d. Date signe	d (Month, E	lay, Year)
10	1/1-		MOILIA	Mule	(MN)	1):	3535	12.	8/29	105	
	Ma		30. Name and address of person	wh completed cause	of death (Item 23a) (Type	, Print)	1 10	,		V 114	
	10		MAVIO Muta	m) 55	> Duth (conterdire	iot lub	4 JUINS	fer imi	را الى) /
	Sta Regista		31. Date filed (Month, Day, Year)		strar's Signature	1. 4.					
	riegisti	uı	AUG &	0 5000	venu is	(COLUE)					

amend 14 per F.H. g851 1/19/06 KBH Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	For State Registrar	State of Ma	ryland / Dep	ertificate of L	ealth and N D <i>eath</i>	ientai Hyg	Reg. No. 20	05 2965
Physicia		Decedent's Name (First, Middle, Las Dylan	Aaron		White		2. Date of Dea Month August	Day Ye	3. Time of Death 5 1:50 p
/Medica Examine	al -	4a. Facility Name (If not institution, give	e street and number)	+ o **	4b. City, Town, or			4c. County of I	Death
Funeral Director		Anne Arundel Me 5. Social Security Number 6. S unknown		(In yrs. last birthda Yrs.	Annapo y) If Under 1 Year Months Days 8	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Aug. 11	v, Year)	Birthplace (State or Foreig Country) Maryland
,		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
ms 23a or 28a-f show	Director	MD Prince Ge	eorges	Suitl	and 10f. Zip Code		Т	10g. Citizen of Wha	1 ☐ Yes 2XXVI
3a or		2339 White Owl	Way		207	46		USA	
5 4	by Funeral	11. Marital Status 1XXNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2XXN If Yes, Give Year or Dates:		3. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☑ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black, Specify B	American Indian, White, etc. Lack
ne. hen "natura e Medical E	Completed	15. Decedent's E. (Specify only highest gra		(Gi	cedent's Usual Occupa ve kind of work done d DO NOT use retired,	luring most of work	ring	16b. Kind of Busin	ness/Industry
tal Hygie d other t	Be Co	17. Father's Name (First, Middle, Last)		N/A				Maiden Sumame)	
d Men marke	္	Charles Aaron V		19b. Ma	illing Address (Street a	Michelle and Number or Rui			ite, Zip Code)
27 is or traus		Charles A. White			9 White Ow				
ent of Hez nt: If Itam ry or othe		20a. Method of Disposition 1 ☐ Burial 2 [X]Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specification)		1	position (Name of rematory or other place	e)	Date 8-2005	20c. Location - Cit	
Departri Importa eny inju once.		21. Signature of Funeral Services Licer	nsee		22. Name and Address Hardesty 12 Ridge1	Funeral 1	Home, P.	Α.	
bur	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	b. Seven Due to (or as a	a consequence of): a consequence of): a consequence of):	Organ	tailu Depr	ession	1	9 days
signed by the attending ph be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of Month	
d pe deta	d by Ph	Part II. Other significant conditions of	contributing to death bu	ut not resulting in the	e underlying cause give	en in Part I.			ute to the cause of death? Probably 4 □Unkno
s certificate has been si lirector, page 2 should I	Completed						24a. Was autor perfo 1 Yes	prior dea	re autopsy findings availa or to completion of cause of th? Yes 2 W No
ector, i	Be	25. Was case referred to medical examiner?	Hospital:		other all DOA Other	26. Place of Dea			
1 P	ation: To	1 Yes 2 No 27. Manne of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Inju		of 28c. Injury	y at		dence 6 Other how injury occurred	
# : 0	Ö	3 Suicide 6 Could not be determined		ury - At home, larm, c. (Specify)	street, lactory, office		28l. Location (City or Tox		or Aural Route Number,
after death. Director: A d in by the fu	ertifi		1	of my knowledge de		ne, date and place	, and due to the	cause(s) and mann	
24 hours after death Funerel Director:	dical Certification:		hysician: To the best of miner: On the basis of and manner sta	examination and/or					
within 24 hours after death To the Funeral Director: / completely filled in by the f	Medical Certifi	(Check only 2 Medical Exa	miner: On the basis of and manner sta	examination and/or	29c. License	pinion, death occu e number			d due to the cause(s)
within 24 hours after death. To the Funerel Director: After completely filled in by the tune	edical	(Check only 2 Medical Exa	miner: On the basis of and manner sta	examination and/orted.	29c. License	pinion, death occu	rred at the time,	date and place, and 29d. Date signed (in August	d due to the cause(s)

State of Maryland / Department of Health and Mental Hygiene 2005 29653 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Ruth Sarah Weddle 2005 cotmber /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner *dagerstown* Washington Washington County Hospital If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Min 1 ☐ M 2 🖫 F 89 219-46-2146 Yrs. Director March 17 1916 Pennsylvania Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28e-f show treumatic event, the Modical Examinar must be notified at 1 ☑ Yes 2 ☐ No Maryland Washington Williamsport Director 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 21795 USA 154 N. Artizan St. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: White 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry d 2 should be filed within 7; th and Mental Hygiene, 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 William Finfrock Christie Gift 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ent: If Item 27 is i 610 Bentley Ct. Hagerstown MD 21740 Janet Shillingberg/Daughter other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. 0 ' 4 □ Donation 5 □ Other (Specify) Sept 6 2005 Waynesboro Pennsylvania Antietam Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown MD 21742 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Přívsician congestive heart Vears /Medical Due to or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physiclen: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician Be Completed by Physician/Medical as the l IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Wonknown Mellitus 24b. Were autopsy findings available prior to completion of cause of death? Cerebrovascular 24a. Was an page 2 s autopsy perform Preumonia 1 ☐ Yes 2 ☐ No 2 1 No 1 ☐ Yes 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Lo this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: Hospitel or Attending 1 Natural 5 Pending investigation after death. Director: Af 1 ∏Yes 2 ∏No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after de • Funerel Directo letely filled in by t determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 24 hoi To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier cynthia Kuther - Sand up D4745 September 2, 2005 (Item 23a) (Type, Print) Nursing Home, 154 North Artizan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -Sands, MD. cynth, a Kuttner Williamsport Maryland Street 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 0 9 2005 Registrar Regues

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			For State Registrar	State of M	viaiylaii		tificate			ITO IVIE	ınaı mygı	g. No. 20	05	29654
	%	26.5	Decedent's Name (First, Midd	dle, Last)			imoate		Joann	2	2. Date of Death		00	3. Time of Death
	hysicia		MARGARET	WILH	HIDE		WACH'	TER		SE	Month EPTEMBEI	R 2, 200	ear	2:15 P M
	/Medic xamin		4a. Facility Name (If not institution	on, give street and number	er)		4b. City, 7	Town, or	Location of			4c. County o		
18			FREDERICK MEM	ORIAL HOSPIT	AL		FRE	DERI	CK			FREDE	RICK	
	neral		5. Social Security Number 214-10-1864	6. Sex 7 1	Age (In yrs. 90	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	B. Date of Birth Sept. 10	Year) 1 01/	9. Birthpl	ace (State or Foreign Vland
Dire	ector		Usual Residence of Decedent			115.					sept. I), 1914	riai	yrand
yland	MO W	Ì	10a. State 10b. Count	•		y, Town or Lo				-			10	d. Inside City Limits
Mar	pelli	ctor	Maryland Fred	erick	Fr	ederic	K							1 ☐ Yes 2 ☐ No
d 21215-0036 Ifled within 72 hours after death with the Maryland Hygiene.	marked other than Tatufar, or tems 4as or 46an anow imatic event, the Medical Examiner must be notified at	i Director	10e. Street and Number 258 Dill A	Avenue			10f. Zip	Code 7 01			10	U.S.A.	at Count	ry?
deat	E DE	Funerai	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.	.S. 13.	Was Decede	ent of Hi	spanic Orig	in? (Spec	rfy Yes or No- ican, etc.)	14. Race		
after a			1 Never Married 2 Ma	ırried 1 ∐ Yes 2)X	Ž ₹\∘		1 □ Yes 2		Specify:	1 4010111	ioan, otc.,	Specify:	White, e	
Dours Tool	al Ex	q p	3XQWidowed 4 □ Divorce	Year or Date	s:									
7 u	a distribution	olete	(Specify only high	ont's Education est grade completed)		(Give	ient's Usual kind of won DO NOT use	k done d e retired	during most	of working	,	6b, Kind of Bus	ness/Ind	ustry
212 d with	Tre S	Completed by	Elementary/Secondary (0-12)	College (1-4d	or 5+)	Caf	eteri	a/ F	food S	ervi	ce	Board o	of Ec	ducation
be file	Vent,	Bec	17. Father's Name (First, Middle									laiden Sumame		
Val Suid b Ment	atic	To		vey O. Wilhi							a Haines			
Mar and 2 sh alth and	or other traumatic		19a. Informant's Name/Relation Mrs. Doris L.	Wenschhof, I	Daught	er 25	8 Dil	(Street a L Av	re., F	rede	rick, M	city or Town, S aryland	2170	$\Omega^{_{ m ode})}$
Baltimore, Maryland 21215-0036 Sermit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene.	y or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (te Mo	Place of Disponentery, cremetery, cremetery.	sition (Nam natory or oti vet Cen	e of her plac eter	y Sept	Da 2. 6, 2		oc. Location - C		
Battir Permit. F Departm	any injury o		21. Signature of Funeral Service		MOO	255	Keen	Address Except	ind Ba	sfor	d PA Fu	neral Ho derick,	ome MD 1	21.701
7 8	100		23a. Part1. Enter the disease,	or complications that caus	ed the deat									Approximate
Phys	ician		Immediate Cause (Final	st only one cause on each	line.									Interval Between Onset and Death
/Me	dical		disease or condition resulting in death)	a. Due to (or	as a conseq	uence of):							- 3	5 days
Exan	niner		Sequentially list conditions.	b										V
N B	Sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or	as a conseq	uence of):								
60, ×	and al-tran	хап	that initiated events resulting in death) Last	c. Due to (or	as a conseq	uence of);								
760,	he burial-transit	calE			•									
687	g pny as the		•	d										
Box eath cert	of for use as the	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor 1 ☐ Live birth			Ectopic pre	anancy				23d. Date		у
the deal	ne an	by Physician/Med	in the past 12 months? 1 ☐ Yes 20 No 9 ☐ Unknown	4☐Pregnant 9☐ Unknown	at time of d		Other (spe					Mont	n [Day Year
Pat th	detach	Phy	Part II. Other significant condit	-		ulting in the u	aderlying ca	uso and	an in Part I		23e Did tob	acco use contrib	uto to the	cause of death?
Records, P.O. Box 68 The law requires that the death certifical	been signed by the should be detached										1 ☐ Yes	5.0		bly 4 Unknown
law re	12 23	Completed									24a. Was an autopsy	24b. We	ere autop	sy findings available
# # f	director, page	Com	,								perform	ed? de	ath?	No
/ita	certificate	Be	25. Was case referred to medic examiner?							of Death (Check only one			
Phys.	⊆ ਜ਼⊟	. To	1 ☐ Yes 2 ☐ Ño 27. Manner of Death	Hospital: 1 Inpa		ER/Outpatien			4 🗆 1401			nce 6 Other		
O 6 4	fune	tion	1 Natural 5 ☐ Pend	/Adamsh	Day Year)	28b. Time of Injury	M	Bc. Injury Work	rat (? Yes 2.∐N		a. Describe nov	w injury occurred	1	
Division of Vital or Attending Physician: Tater death.	in by the	Ifica	3 Suicide 6 □ Could	not be 28e. Place of	Injury - At ho	ome, farm, str	eet, factory,					eet and Number	or Rural	Route Number,
al or safte	i pe	Certification:	4 Homicide deter	building,	etc. (Specify	y)					City or Town,	State)		
Div	to the Funeral Directompletely filled in by		(Check only *2 Medica	ing Physician: To the be al Examiner: On the basis	st of my kno of examina	wledge, death	occurred a	at the tim	ne, date and	place, an	id due to the car	use(s) and man	ner as sta	ited.
the I	mplet.	Medicai	one) 29b. Signature and title of certif	and manner	stated.				number					
5.25	2 8	T	200. Orginature and time of Collins	Rada	~	~	290.		397	7/	29	d. Date signed	WORKE, D	7
1			30. Name and address of perso	n who completed cause of	f death /Item	23a) (Type	Print)	, (211			1/2/2	3	
	1		Robert L. Ka					Sti	reet,	Fred	erick,	MD 2170:	L	
5	Sta		31. Date filed (Month, Day, Yea SEP 0)							
, A	legistr	ar	SET U	3 7007	المحد المساكنا والأواد	ture A	BOOM STORY							

State of Maryland / Department of Health and Mental Hygiene 005 29655 For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month **Physician** Webb Bettv Jolene AUGUST 31 2005 10:45 A^M /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ALLEGANY MEMORIAL HOSPITAL CUMBERLAND If Under 1 Year | If Under 24 Hrs.
Wonths Days Hours Min. 8. Date of Birth (Month, Day, Sep 29, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖫 F Yrs 235-42-7487 76 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County worle the Medical Examinating must be notified at MD Allegany Oldtown 1 ☐ Yes 2√☐ No Completed by Funeral Director 28a-1 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or itams 23a or 18103 Old Braddock Trail, SE 21555 USA filed withIn 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white 3 ☐ Widowed 4 ☐ Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 5+ Charles County School Teacher .. Pages 1 and 2 should be filed w tment of Health and Mental Hygien tant: If item 27 is marked other ti jury or other traumatic evant, III 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Havnes Stockwell Ina (Marshall) Stockwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) husband 18103 Old Braddock Oldtown MD 21555 Lawrence Webb 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Depertment of Important: If any injury or once. 9/2/2005 Rocky Gap Veterans Cemetery MD Flintstone 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, P.A. 21. Signature Funeral Service Licer 108 Virginia Avenue; Cumberland, MD 21502 23a Perit. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Čause (Final Physician a. ACUTE MYOCARDIAL INFARCTION disease or condition resulting in death) 5 MINUTES /Medical Due to (or as a consequence of) **Examiner** CORONARY ARTERY DISEASE 5 YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner sician and a burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 Yes 2 No 3 Probably 4 Unknown CHRONIC RENAL FAILURE, CHRONIC OBSTRUCTIVE PULMONARY 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No DISEASE, DIABETES MELLITUS, H/O CORONARY ARTERY BYPASS 24a. Was an Yes 2 No SURGERY Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2 K ER/Outpatient Other: ို 1 ☐ Yes 2 🕱 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA o 28a. Date of injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural Division 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident hours after deat 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours are:
To the Funeral Diract ģ 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified ./(Cm D19318 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N Ranjithan M.D. 517 Oldtown Road Cumberland MD 21502 32 Registrar's Signature State SEP 0 9 2005 Registrar

		State of Maryland / Department of He	ealth and M	lental Hy	giene 2	005	20050
			Death	2. Date of De	3	000	
Physicia	n	1. Decedent's Name (First, Middle, Last)		Month	, Day	S a WS	3. Time of Death
/Medica		Terry Lane Willis 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or L	Location of Death	carya		nty of Death	1101
LXamine	-1	Peninsula Regional medical Center Salis	sburg	V	W	Citrici	9
Funeral	17	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da	y, Year)	Cour	place (State or Foreign ntry)
Director	}	219-62-8396		Sept.14	,1952	Mary	land
yland	Ì	10a. State 10b. County 10c. City, Town or Location				1	0d. Inside City Limits
e Mar	cto	MD Talbot Easton					X XYes 2 No
Aith th		10e. Street and Number 10f. Zip Code 216	01			of What Cour	
death with the Maryland ms 23e or 28a-1 show	era	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of His	spanic Origin? (Spe	ecify Yes or No		Race - Americ	
21215-0036 21215-0036 within 72 hours after death with the Marylan piene. I than "natural", or teems 23e or 28a-1 show the Medical Examiner must be notified at	by Funeral Director	Armed Forces? If Yes, specify Cuban, 1 □ Never Married 2 □ Married 1 □ Yes 2 □ Never Married 2 □ Married 1 □ Yes 2 □ Never Married 2 □ Ne	Specify:	Rican, etc.)	E	Black, White,	
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nd 212 brd 212 al Hygiena. other than	шо	College (1-4or 5+) 12 Disabled			N,	/ A	
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re, Maryland 2 s 1 and 2 should be filed the alth and Mental Hygitem 27 ie marked othe other traumatic event.	1	19a. Informant's Name/Relationship (Type, Print) Naomi L. Willey/ Mother 19b. Mailing Address (Street ar.) 505 Hazelwo	od Driv	e, Eas	ston,	MD 2	1601
re, s 1 an f Heal item 2	1	20a. Method of Disposition 20b. Place of Disposition (Name of		Date	20c. Location	on - City or To	own, State
Page nent o		1 ★ Burial 2 □ Cremation 3 □ Removal from State 1 □ Onation 5 □ Other (Specify) Hillcrest Cemet		8/05	Feder	alsbur	g, MD
Baltimore, Mapore, Maporent. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other trategrates.		21. Signature of Funeral Service Licensee 22. Name and Address 216 N. Mair	h r	amptom derals	Fune	ra1 H D 2163	lome, P.A. 32
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line.					Approximate Interval Between
Physician	- 1	Immediate Cause (Final disease or condition resulting in death)					Onset and Death
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cuted	Examiner	cause. Enter Underfying Cause (Disease or injury that initiated events c.					
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of Vital Records, P.O. Box 6 Physician: The law requires that the death certificate has been signed by the attending of the director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d.	Date of delive	∍ry
O. B.	sicia	In the past 12 months? 1 Yes 2 No 1 Yes 2 No				Month	Day Year
P.O. that the deed by the detached	Phys	9 Unknown	a in Dant I	22a Did to		antributa to th	ne cause of death?
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cord w requir	Completed	Cherry De la		24a. Was	an 24	b. Were auto	psv findings available
I Rec The tav	ошо	The state of the s		autop perfo	rmed? 2 No	prior to condeath? 1 Yes	psy findings available mpletion of cause of
ital Fien: The	Be C	25. Was case referred to medical examiner?	26. Place of Death			10 100	20110
of Vital Records, Physician: The law requires this certificate has been signeral director, page 2 should be	P.	1 Yes 2 No Hospital: Unpatient 2 ER/Outpatient 3 DOA	4 🔲 Nursing nor				y)
On C ding P h. After t	lon:	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Section Injury 10 Metural 5 Pending Injury 11 Type	at ? es 2 □No	28d. Describe h	now injury occ	curred	
Division I or Attending after death. Director: After din by the fune	ficat	3 Suicide 6 Could not be 28e, Place of Injury - At home, farm, street, factory, office		28f. Location (S	Street and Nu	mber or Rura	l Route Number,
Div	Certification:	4 Homicide determined building, etc. (Specify)		City or Tox	m, State)		
	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time 2 Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated.	e, date and place, a inion, death occurre	and due to the ed at the time,	cause(s) and date and plac	manner as si	tated. the cause(s)
To th within To th comp	Me	29b. Signature and title of certifier 29c. License	number		29d. Date sig	ned (Month,	Day, Year)
			MIN		8/5	8/01	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	/	100	7/8	0/	
Stat	e	31. Date filed (Month, Day, Year) 32. Regisfrar's Signature	SDUTY	m	2/80	2./	
Registra		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Heiche M. E. Carroll St. Sul 31. Date filed (Month, Day, Year) AUG 2 9 2005 AUG 2 9 2005					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 7:15 AM 31, 2005 Mildred F. Yoder August 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Garrett Grantsville Goodwill Mennonite Home 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Yea If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Days Hours Min Months 1 □ M 2 🔀 F Pennsylvania Yrs Feb. 24,1913 214-30-9973 92 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Salisbury Somerset 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 15558 1741 Savage Road 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 🍎 No If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 □ Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) unknown William Loechner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1763 Savage Road, Salisbury, PA 15558 Earl A. Yoder/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Sept. 3,2005 Springs, PA 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Springs Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Newman Funeral Homes, P.A. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee P.O. Box 275, Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heardfailure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) IROSEPSIS WEEK. TNEMIA Due to (or as a consequence of): GASTROINTESTINAL BLEEDING. Due to (or as e consequence of): 23b. Did tobecco use contribute to the cause of deeth? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 127 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy

Physician /Medical Examiner

attending physician and for use as the burial-transit

: After this certificate has bean signed by the a stuneral diractor, paga 2 should ba detachad !

aftar daath. naral Director: A

within 24 hours a

To the Funaral C

complataly filled

or Attanding Physician: The law raquiras that tha death certificate be axecuted

Division of Vital Records, P.O. Box 68760.

Physician/Medical Examiner

Completed by

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Certification:

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Physician

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10a. State

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Funeral Director

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parmit. Pages 1 and 2 should be filed within 72 hours aftar death with tha Maryland Department of Health and Mantal Hygiane. Important: If than 27 is marked other than naturel; or items 22 and early Injury or other trainment.

Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Diabetes Mellitus

1 Yes 2 No

1 Yes 2 10

26. Place of Death | Check only one 25. Was case referred to medical 1 ☐ Yes 2 No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28a. Date of Injury (Month, Day Year)

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

27. Manner of Death 5 Pending investigation 1 Natural 2 Accident

6 Could not be determined 3 Suicide 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

LettifyIng Physiclen: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 58655 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P.O. Box 265, 32 Corporate Dr. Grantsville Md. 21536 SABAHAT NAWAB)
31. Date filed (Month, Day, Year)

SEP 2005 -



State Registrar

		1 - StateUnpend Item 23a, I	ot.II,27 pe	r meg	Mileale of De	05 _{th} tas	2. Date of De		5 29658
Physici /Medio		Robert Craig Anderson	ı, Jr.					ber 7, 200	5 1248 P M
Examin		4a. Facility Name (If not institution, give street a 1729 McHenry Street	and number)		4b. City, Town, or Lo Baltimore	ocation of Death		4c. County of Di	eath
uneral Director		5. Social Security Number 6. Sex 218–17–9838	7. Age (In yrs. It	ast birthday) Yrs.	If Under 1 Year If	Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 11/22	th 9.8 17, Year) 9.8 2/1975 MD	Birthplace (State or Foreign Country)
M. T		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
a-f sho	tor	MD		timore					1 es 2 □ No
or 28 be no	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	
TIB 234	erai	1729 McHenry Street 11. Marital Status 12. Wa	as Decedent Ever in U.S	S. 13. \	21223 Was Decedent of Hispa	anic Origin? (Spe	cify Yes or No	United St	ates
ral, or iter Examiner	by	Never Married 2 Married 1 □	med Forces? Yes 22100 Yes, Give ar or Dates:		Vas Decedent of Hispa f Yes, specify Cuban, M I ☐ Yes 2 No 5	Mexican, Puerto I Specify:	Rican, etc.)	Black, W	hite, etc.
rygener sther than matural, or items 23s or 28s-f show ent, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) 12 Co	bleted) tlege (1-4or 5+)	(Give life. L	dent's Usual Occupation kind of work done duri DO NOT use retired) Entry Cler	ing most of workir	ng	16b. Kind of Busine Newspaper	,
_ >	Be	17. Father's Name (First, Middle, Last) Robert Craig Anderson	Sr			. Mother's Name Sandra M.		Maiden Surname)	
marked umatic e	ဥ	19a. Informant's Name/Relationship (Type, Pri		19h Mailin	g Address (Street and				- Zin Codol
f Item 27 is marked r other traumatic e		Sandra M Andorson .	ther		McHenry St				
if Item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remova	I from State	тетелу, сгел	sition (Name of natory or other place)	5	sep 13	20c. Location - City	or Town, State
Important: if Ite any injury or ot once.	-	4 □Donation 5 □ Other (Specify)	Che		ke Cremator			Beltsville	, Maryland
any ir		21. Signature of Funeral Service Licensee	In Moly	43 8	Name and Address or remation and 717 Green Pa	d Funeral	Altern	atives	aryland 21286-
rsician ledical aminer		resulting in dealth)	herosclerot th Bacterem Due to (or as a consequ	ic Car ia ence of):					Approximate Interval Between Onset and Death
To the Funeral Director: Atter this certificate has been signed by the ettending physicien and Completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	cal Examine	cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequ Due to (or as a consequ						
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ached for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	es, outcome of pregnan]Live birth 2 Fetal]Pregnant at time of de]Unknown	death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
ould be de		Part II. Other significant conditions contributin Addison's Disease	ng to death but not resul	lting in the un	derlying cause given in	Part I.			to the cause of death? Probably 4 MUnknown
r, page 2 st	Completed by							sy prior to med? death?	autopsy findings available o completion of cause of ess 2 \(\) No
s ceru	To Be	25. Was case referred to medical examiner? 1XXes 2 □ No Hospital	: 1 ☐ Inpatient 2 ☐ E	R/Outpatient	0.1	Place of Death			ecify) at scene
or: After thi		2 ☐ Accident investigation		28b. Time of Injury	28c. Injury at Work?			ow injury occurred	echy at scene
led in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e.	Place of Injury - At hon building, etc. (Specify)	ne, farm, stre	eet, factory, office	2	8f. Location (S City or Tow	treet and Number or I n, State)	Rural Route Number,
pletely fil	edicai		To the best of my known the basis of examination manner stated.	rledge, death on and/or inv	occurred at the time, destigation, in my opinion	date and place, ar	nd due to the o d at the time, o	cause(s) and manner a date and place, and di	as stated. ue to the cause(s)
250	Σ	29b. Signature and title of certifier			29c. License nu			29d. Date signed (Moi	nth, Dey, Year)
NO	-	30. Name and address of person who complete		23a) /Tv 5	O.C.M.E	E		September	8, 2005
	1	50. Hairie and address of person who complete	u vause of death (IIem)	دعم) (۱۷۵۸, F	-11111)				
9		31. Date filed (Month, Day, Year)		111 P€	enn Street,	Baltimo	ore, Ma	ryland 212	01

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			For State Registrar	State of Mai	ryland / Do (epartment (C <i>ertificate</i>	of Health and M of Death	Mental Hygi R•	ene 200	5 29659
	Discontact and)	1. Decedent's Name (First, Middle, Las	st)				2. Date of Death Month	Day Yea	3. Time of Death
	Physici /Medic		James	Kenneth		Allis	Sr.	9	7 2005	
Ì	Examin	er	4a. Facility Name (If not institution, give	street and number)		4b. City, To	vn, or Location of Death		4c. County of De	ath
4	/		414 Darlene Ave.		d t t t t.	Linth		T:	Anne Aru	
ľ	Funeral Director		178-22-3059	ex 7. Age	(In yrs. last birth	Months D	Year If Under 24 Hrs. Aays Hours Min.	8. Date of Birth (Month, Day, 12-5-1	9. 8 930 M	irthplace (State or Foreign Country) D
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Aaryla Febo	or								1 ☐ Yes 2 🖾 No
	28a-	Director	MD Anne Aru 10e. Street and Number	ndel	Linthic	10f. Zip Co	de	10	g. Citizen of What (Country?
	3a or	0	414 Darlene Ave.			210				Southly.
	death	Funeral	11. Marital Status	12. Was Decedent Ev	er in U.S.		of Hispanic Origin? (Sp Cuban, Mexican, Puerto		U.S.A. 14. Race - An	
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7	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23a or 28a-1 ehow tha Madisal Exama in roual be notified at	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. D	ecedent's Usual C Give kind of work of ife. DO NOT use r	ccupation one during most of work	ang 1	6b. Kind of Busines	ss/Industry
121	within then	Jub	Elementary/Secondary (0-12)	College (1-4or 5+) 4			rrant Offic	0.76	U.S. Ar	
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a	should be nd Mental marked o	To B	Kenneth Allis				Anna C	rayton		
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	and 2 ealth m 27		Mrs. June Allis /	Wife			Ave. Linth	and the same of th	21090	
o e	Pages 1		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □	Removal from State	20b. Place of D cemetery,	isposition (Name of crematory or other	of r place)	Date 2	Oc. Location - City of	or Town, Slate
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Box	death certif e attending id for use as	an/h	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2		3 ☐Ectopic pregn	ancy		23d. Date of d	
o.	0 0 0	Physician/M	1 Yes 2 No	4□Pregnant at tir 9□Unknown	ne of death	5 ☐ Other (specif			Month	Day Year
۳.	res that t igned by be detac		Part II. Other significant conditions co	ontributing to death but	not resulting in the	he underlying caus	e given in Part I.	23e. Did toba	acco use contribute	to the cause of death?
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		Co						perform	ed? death?	s 2 No
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	ital or is after al Dire	Certification:	4 Tromoto	building, etc.	(Зрвску)			City or Town,	State)	9
	To the Hospital or within 24 hours atter To the Funeral Director Completaly filled in E	edical	29a. Certifier (Check only one) Certifying Physical Example 2 Medical Example 1	ysician: To the best of interior interior in the basis of example and manner state	xamınation and/o	death occurred at the or investigation, in	ne time, date and place, my opinion, death occur	and due to the cau red at the time, dat	use(s) and manner a te and place, and du	as stated. ie to the cause(s)
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	15		30. Na e address of pers o c	completed cause of deep	th (Item 23a) (Ty	(pe, Prink)	Ave 1	Soltin	vave la	1 > 71779
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	Registr	ar	SEP 1 3 20	05 Mana	15 1	Coarles				

			State of Market State of Marke	anyland 6 Dep Ce	artment of He ortificate of D	ealth and Me Death	ental Hygi	ene 2005	29660
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Mary Moore Bey				2. Date of Death Month	Day Year	3. Time of Death
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	F		5. Social Security Number J 6. Sex 7. Ag	e (In yrs. last birthday	If Under 1 Year	ELPN (If Under 24 Hrs.	8. Date of Birth	Prince 9. Bir	
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	the Mary 28a-f sh	ctor	MD PrinceGeorges	Ade	elphi				41 8 Yes 2 1 No
	£ 6 9	Funeral Director	10e. Street and Number 27()2 Curry Drive		10f. Zip Code	20783	10	g. Citizen of What Co	ountry?
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98	or ite	y Fur	Armed Forces? 1 Never Married 2 Married 1 Yes 2 Married 1 Yes, Give	No	If Yes, specify Cuban,	, Mexican, Puerto H Specify:	lican, etc.)	Specify: 12	look
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щÕ	0 = =		1	Cedu	matory or other place)	09.15		Baltim	
Baltimore,	permit. Pages 1 a Department of Hee Importent: If Item eny injury or othe		21. Signature of uneral Service Lionny,		2. Name and Address Jaughn C. (5151 Balto.	of Facility Sycene Fu Natil Pik	eneval s	seniras MD 21720	
b			23a. Pan Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not en					Approximate Interval Between Onset and Death
	Physician /Medical		resulting in death)	STAGE RE	ENAL DIS	EASE			lmonth
	Examiner		Due to (or as	a consequence of):					
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence of):					
	xecute and	Examiner	that initiated events	a consequence of):					
8760,	eath certificate be executed attending physician and for use as the burial-transit	dicai E	d.						
9	ertifica ling ph	0	IF FEMALE: 23c. If yes, outcome	of programmy				1	
Вох	death c	Physician/M		2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of de Month	Day Year
P.O.	t the by th ache	hys	9 ☐ Unknowń				T	_	
	S	þ	Part II. Other significant conditions contributing to death b	ut not resulting in the u	underlying cause given	n in Part !.	23e. Did toba	acco use contribute to 2 X No 3 ☐ Pr	the cause of death?
Vital Records,	> Q 0	Completed					24a. Was an	24b. Were au	utopsy findings available
Re	9 1 9	ошо					autopsy perform	ed? death?	completion of cause of
/ital	Physicien: Th this certificate ral director, pag	BeC	25. Was case referred to medical examiner?			26. Place of Death	(Check only one)	
of	hys this al dii	.: To	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatie 27. Manner of Death 28a. Date of Inju	ry 28b. Time o				nce 6 Other (Spe	cify)
ion	nding F ath. r: After e funera	atior	1 ★Natural 5 ☐ Pending (Month, Day 2 ☐ Accident investigation	y Year) Injury	Work?	es 2 □ No			
Division	el or Attending F s atter death. il Director: After id in by the funer.	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injude building, etc.	ury - At home, farm, st c. (Specily)	reet, factory, office	28	3f. Location (Stre City or Town,	eet and Number or Ru State)	ural Route Number,
1	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edicai Ce	29a. Certifier (Check only 1 Certifying Physician: To the best of the pass o						
	thin 24 thin 24 the F mplete	Medi	one) and manner sta 29b. Signature and title of certifier	ated.	29c. License r			d. Date signed (Mont	
	or Too	-	Abill Le Pott	M.D.					
3	9		30. Name and address of person who completed cause of d PHILLIP W. POTH, M.D.	eath (Item 23a) (Type,	Print) Ave. S	ilverspri	ng MD	20901	- ROSTATE
	Sta		31. Date filed (Month, Day, Year) 32. Registra	ar's Signature			J	- •	
	Regist	ar	SEP 1 3 2005	was St. A	Joseph .				

			1- State of Manyland / Department of Health and Mental Hygiene 2005 2966 Certificate of Death Registrar
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Josephine Jan Sutherland Brown Josephine Jane Sutherland Brown On Pay Year Year 11: 30M
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. Ward
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 1 Hoder 1 Year 1 Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Country) 9. Birthplace (State or Foreign
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Howard Columbia 1Yes 2 \(\overline{\text{VNO}} \)
	with the h	i Direct	10e. Street and Number 5907-2 Tamar Drive 10f. Zip Code 21045 USA
36	72 hours after death with the Maryland netural', or items 23a or 28a-f show dical Examiner must be notified at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Never Married 2 Married 3 Widowed 4 Divorced 1 Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 14. Race - American Indian, Black, White, etc. 14. Race - American Indian, Black, White, etc. 14. Race - American Indian, Black, White, etc. 15. Specify: Black
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan at of Health and Mental Hygiene. If item 27 is marked other than "netural", or items 23a or 28a-f show or other traumatic event, the Madical Examiner man be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th arade 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housing Authority Housing Authority
Maryland	uld be file Aental Hyg rked othe tic event,	To Be C	17. Father Stame (First, Middle, Last) Daniel Sutherland EVa Hicks
	and 2 sho saith and h n 27 is ma		19a. Informant's Name/Rejationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcell L. Brown/Husband 5907-2 Tamar Drive Columbia MD 21045
Baltimore,	Pant and		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of semetary, crematory or other place) Good Shepherd 20c. Location - City or Town, State Ellicott City i MD
Balt	permit. Pa Departmen Important: any injury		21. Signature of Funeral Service Licenses 22. Name and Address of Facility Vaughn C. Greene Funeral Services SISNEALHMOYE National Pike Balto MD 21229
	Physician /Medical		23a. Part1. Entel-the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC Pauciculto Cause? Metastatic Pauciculto Cause?
	Examiner	er	Due to (or as a consequence of): Sequentially list curuliture, if any, leading to immediate Due to (or as a consequence of):
90,	eath certificate be executed attending physician and for use as the burial-transit	i Examiner	If any, leading to immediate cause. Enter Underlying Cause Disease or injury that imitated events c. resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):
68760,	tificate t ng physi as the t	fedical	d
.O. Box	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
Δ.	n requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 Ho 3 Probably 4 Unknown
Il Records,		Completed by	24a. Was an autopsy performed? 1 Tyes 2 Two
Vital	Physician: The this certificate hiral director, page	Be	25. Was case referred to medical examiner? 1 Yes 22No Check only one 1 Inpatient 2 ER/Outcatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
Jo L	g Phys ter this neral di	n; To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred
Division of	To the Hospitel or Attending Phwitin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral.	Certification;	2 \(\text{ Accident} \) 3 \(\text{ Suicide} \) 6 \(\text{ Could not be determined} \) 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined)
Ö	pitel or ours after shall bird in billied in b		4 Homicide building, etc. (Specify) 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	the Hos nin 24 ho the Fun npletely i	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
)	o viti	2	29b. Signature and title of certifier D 3 8509 29c. License number 29d. Date signed (Month, Day, Year) September 9 2005
1	0-1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nicholas Routrolakts 11065 Little Parrixent Ptax Columbia MB 21044
	Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neutron Route and 1065 Little Particent Phys Columbia MD 21044 31. Date liled (Month, Day, Year) SEP 1 3 2005 SEP 2 3 2005

Amend item#8, perFin, G847, 9/22/05 TT State of Maryland / Department of Health and Mental Hygiene 2005 29662 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Bullock 3:40AM Cora 05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Joseph Ritchie Hospice Baltimore NIA If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Y2/9/19219. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 84 Yrs. 217.20.5220 1 M 2 XF NC Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits NA r Items 23s or 28e-f eh iliter toust be posified Baltimore MD 1 MYes 2 □ No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2919 W. Lanvale Street 21216 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) be filed within 72 hours after 1 Never Married 2 Married ō 1 ☐ Yes 2 ☑ No Specify: Specify: Black 17 is marked other than "netural", of traumatic event, the Madical Exa 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed with and Mental Hygiene. State of Maryland 17. Father's Name (First, Middle, Last) Data Entr 18. Mother's Name (First, Middle, Maiden Sumame) land Be William H. Harper Sarah Newton 2 19a. Informant's Name/Relationship (Type, Print)(Daugh 😭 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Heatth and Important: If Item 27 is m any injury or other traum once. Barbara A. Fitzgerald 2801 Rockrose Avenue Balto. ND 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Baltimore MD 09.14.05 ARBUTUS * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Vaughn C. Greene Funeral Services 515/Baltimore National Pike Batto. MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medicai IF FEMALE: . If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregna 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 PNo Year Month Dav 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Nown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate ? 2 No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence ၉ 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) 27. Man r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After Hospitel or Attending 5 Pending investigation 1 V atural 2 No 1 Tes 2 Accident Director: 6 ☐ Could not determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Fune completely f Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29c. License number 29d. Date signed (Morth, Day, Year) 29b. Signature and title of certifig 0 gistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2005 29663 1 - State Registra Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 08 **Physician** Betty Brostoff 26 2005 11:30a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 93 Months Days Hours 1 ☐ M 2 🖫 F 100-01-3397 Director 10-03-1911 Poland Poland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director MD 1 ☐ Yes 2 ☑ No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 6111 Montrose Rd. #403 20852 USA or Itams 23e Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or Ital mojoriant: or other traumatic event, the Modral Examinate Page. ☐Yes 2 🛣 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White δ 3 ☑ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk US Marshall's Office 12 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jack Sularski Eva Rosenshein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rona Leyman/daughter 10413 Samaga Dr. Oakton VA 22124 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 08-30-2005 Beltsville MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rapp Funeral & Cremation Service 933 Gist Ave Silver Spring MD 20910 mo1358 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final **Physician** Chronic Debility disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner End Stage Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, physician Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has page 2 1 Yes Division of Vital 2**∑** No Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: 2 4 Nursing Home 5 Residence 6 Nother (Specify) Hasey 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Certification: After Injury at Work? 1 Natural 2 Accident 5 Pending Injury death. investigation 1 ☐ Yes 2 ☐ No Director; 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral 6 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature 29d. Date signed (Month, Day, Year) 0 who completed cause of death (Item 23a) (Type, Print) Charles Harrison 6001 Muncaster Mill Rd. Rockville MD 20855 31. Date filed (Month, Day, Year) State Registra 3 2005

			For State Registrar	State of Maryla	•	artment of He			jiene leg. No.	700	29664
	Physici		1. Decedent's Name (First, Middle, La	BARTLET				2. Date of Dea Month	th Day	Year	3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, giv	re street and number)	PITAL	4b. City, Town, or	Location of Death			County of Death	DUKKY
	Funeral		5. Social Security Number UNK 6.5	Sex 7. Age (In yrs		- 4 4	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	1		place (State or Foreign
	Director		Usual Residence of Decedent	XXVI 201 / 1	Yrs.			08-25-	1934	Was	hington DC
	arylanc show	_	10a. State 10b. County		ity, Town or L						10d. Inside City Limits 1 X Yes 2 No
	the Ma	ecto	MD Montg	omery S	Silver	Spring 10f. Zip Code			10g. Citiz	en of What Cou	
	h with	al Di	3210 Norbeck Rd.	#312			20906		USA		
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 ie marked other then "naturel; or items 23a or 28a-1 show other treumatic event, the Madical Examinations Leaintilies at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in I Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates:	J.S. 13.	Was Decedent of His If Yes, specify Cubar 1☐ Yes 2\overline{2}\$No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		4. Race - Amen Black, White, Specify: Whi	etc.
Maryland 21215-0036	within 72 ho ane. then "natur ne Medical I	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		(Give	edent's Usual Occupa e kind of work done d DO NOT use retired) fice Manas	uring most of work	ing		nd of Business/Ir	dustry
d 2	Hygie other	Be Co	17. Father's Name (First, Middle, Last	· · · · · · · · · · · · · · · · · · ·	01		18. Mother's Name	(First, Middle,			
ylar	s should be filed withir and Mental Hygiene. Ie marked other then eumatic event, the Me	To B	Norris Bartlett						Pit		
	Health and the tem 27 is mother treum		19a. Informant's Name/Relationship Joseph Bartlett/			ing Address (Street a 210 Norbec			r Sp	ring MD	20906
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☆Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Speci	Removal from State (Place of Disp cometery, cre Thesape	osition (Name of ematory or other place eake Crema	tory 09-1	Date 1-2005		eltsvill	
Balt	permit. Departr Importa any inju		21. Signature of Funeral Service Lice	nsee Moi:		22. Name and Addres Rapp Fune: 933 Gist	ral & Cre				
	Pnysician /Medical		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that caused the dear one cause on each line. Due to (or as a conse	TATIL	nter the mode of dying		or respiratory an			Approximate Interval Between Onset and Death
	Examiner	ier	Sequentially list conditions, if any, leading to immediate	b. SEPTCE	AIM						I WEEK
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	day, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a conse	equence of):		_				
9	rtificate ng phys	Medic	IF FEMALE:	u.							
.O. Box	that the death certifica ed by the attending pla detached for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal déath 3	□Ectopic pregnancy □ Other (specify)			2	3d. Date of deliv Month	ery Day Year
α.	w requires that the been signed by should be detace	þ	Part II. Other significant conditions	contributing to death but not re	esulting in the	underlying cause give	n in Part I.	23e. Did to		se contribute to	the cause of death?
I Records,	The law requate has been page 2 should	Completed			-			24a. Was autop perfor 1 Yes	sy	prior to co death?	opsy findings available ompletion of cause of 2 No
of Vital	Phyeicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Deat				
ion of		ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Z8b. Time Injury	of 28c. Injury Work	at	me 5 Resid 28d. Describe h			fy)
Division	the Hospitel or Attending hin 24 hours after death. the Funerel Director: After Inpletely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined		home, farm, s	treet, factory, office		28f. Location (S City or Tow			al Route Number,
	To the Hospitel or A within 24 hours after To the Funerel Direction Distribution of the Completely filled in by	Medical (hysician: To the best of my kuminer: On the basis of examinand manner stated.							
	To the within 2 To the comple	Mec	29b. Signature and title of certifier			29c. License	number		29d. Date	signed (Month,	Day, Year)
)	~) saten			SITA	297107		DE	250	5
,	21		30. Name and address of person who	completed cause of death (It	om 23a) (Type	NE HILL	PDRIVE	DINE	Yr	15 208	32
	Sta Regist		31. Date filed (Month, Day, Year) SEP 1 3	2005 32. Segistrar's Sign	nature.	perte			-1		

			1 - For State Ragistrer 1. Decedent's Name (First, Middle		Marylar	nd / Depa	artmen rtificat	t of H e of L	ealth a Death	and M	lental Hy	Reg. No.	005	
	Physici	ian	t-marin	i, Lasi)		BLA:					Sep	Day	Year	3. Time of Death
	/Medie Examir		EILEENE 4a. Facility Name (If not institution	, give street and num	ber)	Den		Town, or	Location of	of Death	256	-	2005 ty of Death	
J.	Examili	ier	305 E. Joppa R		,		12. 2.,,,		Tows				imore	
ı	Funeral Director		5. Social Security Number 219-28-6134	6. Sex 7	'. Age (In yrs. 72	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da 01/2	7/1933	9. Birthp	lace (State or Foreign try)
	p ,		Usual Residence of Decedent 10a. State 10b. County		10a C	ty, Town or Lo	- dian							
	ehov	7	,	imore		wson	ication						"	0d. Inside City Limits 1 ☐ Yes 2 No
	the N	Directo	10e. Street and Number				10f. Zip	Code				10g. Citizen of	Mhat Coun	
	Mith Ba or	ă	305 E. Joppa R	oad				286				United		
	me 2;	Funeral	11. Marital Status	12. Was Deced	lent Ever in U	J.S. 13.	Was Dece	dent of Hi	spanic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)	14. Ra	ce - Americ	an Indian,
30	4 within 72 hours after deeth with the Maryland liene. r then "naturel", or lieme 23a or 28a-f ehow the Madikal Examiner must be natiliad at	by Fur	1 Never Married 2 Marri	Armed Forcied 1 Yes 2 If Yes, Give	No	1	it Yes, spe 1 ☐ Yes			i, Puerto	Hican, etc.)		ack, White, o	
รุ	2 hou	ted	15. Decedent	's Education		16a. Dece	dent's Usua	al Occupa	ation			16b. Kind of		
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	d be filed antal Hygie and other c event, II	Be	17. Father's Name (First, Middle, Maurice Dubois			1					e (First, Middle, Finn	Maiden Suma	ıme)	
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<u>ra</u>	sician: Th certificete rector, pag	0	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes		1 ☐ Yes	2 No
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on of	Attending Physician: " r death. ector: After this certifice by the funeral director, p		27. Manner of Death 1 S Natural 5 Pendin 2 Accident investig		Injury , Day Year)	28b. Time of Injury	M 2	8c. Injury Work			28d. Describe h			
DIVISION	I or Attendi after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could r 4 Homicide determi	not be 28e. Place of	of Injury - At h g, etc. (Speci	ome, farm, str fy)	eet, factory	, office			28f. Location (S City or Tow	itreet and Num n, State)	ber or Rural	Route Number,
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)	Or		1 /and	res / of			D	35	265			9/9	105	
(31		30. Name and address of person	who completed cause	of death (Iter	т 23а) (Туре,	Print)						1	
	V		3100 Wyman 1	Park DR.		BA	Ism	184	ne	0	2121	11		
3	Sta Registi		31. Date filed (Month, Day, Year)	005 Re	gistrar's Sign	ature	de la				212,			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2005 29666 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 11 2005 **Physician** 8:30 a Doris Marie Birkett /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Catonsville St. Martins Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept 30, 1920 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 □ M 2 🛛 F 215-01-7220 84 Director Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County item 27 is marked other than "naturel", or Items 23a or 28e-f show other treumatic event. It is Modical Exercitary ust be notified at 1 ☐ Yes 2X No Director Maryland Catonsville Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1075 Craftswood Road 21228 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 72 hours after ∐Yes 2 XNo fYes. Give 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specifyþ if Yes, Give Year or Dates: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Irving G. Tolson Esther Marie Schweitzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 1 and 2 s of Health an item 27 is Thomas H. Birkett, Jr. / Son 7204 Inwood Avenue, Catonsville, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages nent of h 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department in importent: if eny injury or * 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 9/14/05 Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. Funeral Service Licenses 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease of complidations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed burial-transit Due to (or as a consequence of): Box 68760. physician Physician/Medical the IF FEMALE esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4☐ Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₹No 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospitel or Attending Pl 24 hours after death.
 Funerel Director: After the Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel of within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 29c. License number 21649 V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILKENS AVE BALTIMULE, MO 21229 3455 KARAN 32. Registraris Signature State Registrar

		l e	1 - State Registrer Amend Ite	State of N							ene g. No. 2 ()	05	29667
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	Funeral			. Sex 7. A	Age (In yrs.	last birthday)	If Under 1 Ye	ear	If Under 24 Hrs.	8. Date of Birth		9. Birtho	lace (State or Foreign
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O. Box	that the death certificed by the attending properties as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 □Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Fetal at time of de	death 3	Ectopic pregna Other (specify				23d. Dai Mo	e of delive	ry Day Year
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Vital	Physiclan: Th this certificate ral director, pag	BeC	25. Was case referred to medical examiner?	Hospital:				Other	26. Place of Death	(Check only one)		
of	Phys r this ral di	. To	1 Yes 2 No 27. Mann Death	1 □ Inpa		ER/Outpatien 28b. Time of	1 3LJ DOA		Nursing Hor	ne 5 🗆 Residen 28d. Describe how)
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	Sta Registr	- 201	31. Date filed (Month, Day, Year) SEP 1 3 2005										

E. ARTHUR BOWEN

State of Maryland / Department of Health and Mental Hygiene 2005 29668 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 09 **Physician** ARTHUR, R. BLOSSER 7:20 AM 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and nun Examiner BALTIMORE WASHINGTON MEDICAL CENTER GLEN BURNIE ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months | Davs | Hours | Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2□F XX Months Days Yrs. Director AUG 3, 1944 WVA <u>236.68.9549</u> Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Itam 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 ☐ No XX Director GLEN BURNIE MD) ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen ol What Country? death v 835 BENTWILLOW DR 21061 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: if Itam 27 is marked other then "natural", or Itel may hiury or other traumatic event, the Madical Examine and. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 🏋 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No ģ Specify: 3 Widowed 4 Divorced XXWHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 WELDER FABRICATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be STELLA HINKEL LLOYD A. BLOSSER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TERRY BLOSSER WIFE 835 BENTWILLOW DR. GLEN BURNIE, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donaţion 5 ☐ Other (Specify) MEADOWRIDGE CEMETERY | SEPT 13,2005 ELKRIDGE, MD Duneral Sacres Licens 21. Sione FINK FUNERAL HOME, P.A. GREGORY FIN 426 CRAIN HWY SW GLEN BURNIE, MD 21061 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARCINOMA OF THE LUNG **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine The law requires that the death certificate be executed Due to (or as a consequence of) sicien a P.O. Box 68760 Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. CONGESTIVE HEART FAILURE 1 Yes 2 No 3 Probably 4 Unknown Completed CHRONIC OBSTRUCTIVE PULMONARY DISEASE 24b. Were autopsy lindings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy performe performed? To the Hospitel or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 ☑ No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death To the Funerel Director:, completely filled in by the f 6 Could not be determined 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number markell & Kun MD D54574 09,09,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mn 21061 GLEN BURNIE MARK KIM, MO 1412 N. CRAIN HWY GA 31. Date liled (Month, Day, Year) 32. Registrar's Signature State Registrar SEP 1 3 2005 Bloques 15

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	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days		8. Date of Birt	th v Year)	9. Birthpl Count	ace (State or Foreign
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	and 2 lealth a m 27 is		Glenda Lee Goodric	(Wife) n - Bell		ue Grove		sex, Mar			,
Baltimore,	of He of He if item		20a. Method of Disposition M□ Burial 2 □ Cremation 3 □ Re		lace of Dispo	sition (Name of natory or other place		Date	20c. Location -		vn, State
Ë	nit. Pages partment of I cortent: If its injury or or		'4 ☐ Donation 5 ☐ Other (Specify)	Mar	yland	Veteran (Cemetery	9/9 2005 (rownsvi	lle,	Maryland
Ba	permit. Page Department Importent: If eny injury or once.		21. Signature if uneral Service Ucense	knurke	В	Name and Address ruzdzinsk 407 Old E	ki Funera	1 Home H	PA Pagoy M	والعجدا	nd 21221
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з, Р	The law requires that the tee has been signed by thoage 2 should be detached.	by P	Part II. Other significant conditions conf	ributing to death but not resi	ulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contr	ibute to the	cause of death?
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ion	Attending I ir death. ector: After by the funer	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		:? /es 2 □ No		, ,		
Division	i e e	ertification:	3 🗆 Suicide 6 🗆 Could not be 4 🗀 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	eet, factory, office		28f. Location (Si City or Town	treet and Numbe n, State)	er or Rural I	Route Number,
	pitel	O	29a. Certifier 1 Certifying Physi	cians To the best of my kee							
	To the Hospitel of within 24 hours at To the Funerel D completely filled in	edical	one)	cian: To the best of my kno- er: On the basis of examinat and manner stated.	tion and/or inv	estigation, in my op	inion, death occur	red at the time, d	ause(s) and mar ate and place, a	nner as stat nd due to th	ed. le cause(s)
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier		0 1	29c. License	number	2	9d. Date signed		
	4 .	-	"aguenne!	rringade	ee_	2 11	1780			2005	
	10+1		30. Name and address of person who con Adnenne McFadd	ripleted cause of death (Item	23a) (Type, F	GREENIT	ST 2	A. Da-	OE MI	712	2) (
• ā	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signal	ture	M	1 D	AL/11/201	ce, i	LIL	VI
	Registr	ar	SEP 1 3 2005	npleted cause of death (Item LN M-D. 32 Registrar's Signar	for						

		CI.	1 - State Unpend Item Registrar	State of M 23a, 27, 28a	larylar -f p e	nd/Depa	artmen 847 rtificat	t of H e of L	ealth a 05 ta Death	and M	ental Hy	giene Reg. No.	05	29670
ı	Physici	an	Decedent's Name (First, Middle, William Bauer	Last)							2. Date of Da Month	oer 08,	Year 2005	3. Time of Death 10:06 AM
)	/Medic Examin		4a. Facility Name (If not institution,	give street and number)		4b. City,	Town, or	Location of	of Death	Бересии		ty of Death	
É			2412 Cidermill F					rkvi						imore
	Funeral Director		5. Social Security Number 212–42–0888	5. Sex 7. A 15 M 2 □ F	ge (In yrs. 6	last birthday) 2 Yrs.	Months	Days	If Under Hours	Min.	8. Date of Bird (Month, Da Oct. 10,	y, Year)	9. Birth Cou Pen	pplace (State or Foreign intry) nsylvania
	put *		Usual Residence of Decedent 10a. State 10b. County		10c Ci	ty. Town or Lo	cation							10d. Inside City Limits
	Maryla i-f eho	tor	Maryland Baltim	ore	, , , , ,	Parkv:							İ	1 ☐ Yes 2 ☐ No
	or 28a	lrec	10e. Street and Number				10f. Zip					10g. Citizen of		untry?
	s 23a	rai	2412 Cider Mill		. Francis III			1234		-1-0 (0		U.S.A.		
036	filed within 72 hours after death with the Maryland Hygione. the then "natural", or items 23a or 28a-f ehow ent, it a Medical Examinational be rediffed at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 2 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces d 1 XX es 2 ☐ If Yes, Give Year or Dates:	? No 	1	Was Dece If Yes, spe 1 Yes		Spanic Origin, Mexican Specify:		cify Yes or No Rican, etc.)	Speci	ack, White	ican Indian, , etc. ite
315-003b	72 ho 'natur	eted	15. Decedent's (Specify only highest	Education grade completed)		16a. Dece	kind of wo	rk done a	lurina mosi	t of worki	ng	16b. Kind of E	Business/I	ndustry
121	s within piene. r then	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	Civil	DO NOT u	se retired,)			Public	c Wor	ks
ב פ	e filed Il Hygi other	BeC	17. Father's Name (First, Middle, L.	ast)		100			18. Mothe	r's Name	(First, Middle,	Maiden Suma		
ya	should be and Mental I marked o	ToE	Paul Stephen Ba								ci nda K			
Maryland	C1 00 -2 40		19a. Informant's Name/Relationshi Kenneth Bauer (-					or, City or Town		
ē,	os 1 and of Health item 27		20a. Method of Disposition		20b. I	Place of Dispo cemetery, crei					ate	20c. Location		
Baitimore,	Pages ment of lant: If it		1 ☐ Burial 2/Coremation 3 4 ☐ Donation 5 ☐ Other (Spe			yview (Crema	tory	S		0,2005			Maryland
E E E	permit. Page Department of Important: If eny injury or		1. Signature of Fundad Service C				1407	OTq 1	Easte	ern A	venue,		P.A Mary	land 21221
	Physician		23a: Part1. Exter the disease, or c shock or heart failure. List o Immediate Cause (Final disease or condition	omplications that cause nly one cause on each Asphyxia	line.							rest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as				-						
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Cause (Disease or injury that initiated events Cause (Disease or injury that initiated events											
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O. Box	at the death certificate by the ettending phys tached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	al déath 3	Ectopic p						ate of delivionth	very Day Year
٦.	as tha	Ď	Part II. Other significant condition	s contributing to death	but not res	sulting in the u	nderlying o	cause give	en in Part I.		23e. Did to	V		the cause of death?
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E E	iician: The cartificate h rector, page		25. Was case referred to medical						26 Place	of Death		2 No	Yes	2 □ No
or Vital	Q 12.	To Be	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpat	ient 2	ER/Outpatier	nt 3 🗆 DC	Othe					her (Speci	(y) SCENE
	a fe		27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investiga	28a. Date of Inj Formath, Di	ury ay Year)	28b. Time o	A M	28c. Injury Work 1 🔲 \		é	ubject		ea dr	ugs and
Division	at or Atte s after de l Directo d in by th	Certification:	3. Suicide 6 ☐ Could no 4 ☐ Homicide determin		njury - At h tc. <i>(Speci</i> t hot	ome, farm, str fy) ne	eet, factor	y, office		F	28f. Location (S City or Tov Parkvil	Street and Num m, State) 24	12 Ci	dermill Rd.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (29a. Certifier (Check only one) 1 Certifying 1 Certifying	Physician: To the best kaminer: On the basis and manner s	of examina	owledge, deat ation and/or in	h occurred vestigation	at the tim	ne, date an	d place, a	and due to the	cause(s) and m	anner as : , and due t	stated. to the cause(s)
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			30 Name and address of person w	CA - Poll		(1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	Penn	Str	eet,	Balt	imore,	Marylar	nd 21	201
	Sta Registi		31. Date filed (Month, Day, Year) SEP 1 3 2	32 Aegist	trar's Sign	ature	e de							

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ORIGINAL

State of Maryland / Department of Health and Mental Hygien 2005 29671 1 - For Stata Ragistrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** q Broadnax George 2005 COUST SEPtember /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MΔ SAINT Agnes HEALthcare SAUTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex Date of Birth (Month, Day, Year 3-1-30 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days **X**□M 2□F Months Hours Yrs 75 Director 239-48-5839 N.C. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Madical Examinar must be notified at Baltimore Yes 2 No NA Director Md. 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? with 21239 USA 1635 Stonewood Ave. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes ¾☐ No Specify: Specify: Black þ 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) STA Longshoreman 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Broadnax Webb Courtney Russell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 2 4 0 7 19a. Informant's Name/Relationship (Type, Print) 7106 Crown Jewels Ct., Frederickbury? Niece Jackie Stephens 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley 9-12-05 Timonium, Md. 21. Signature of Funeral Service Licenses 21202 22. Name and Address of Facility Baltimore, 1101 E. North Ave. March F. H. East I adys wane 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final Physician Atheroscleron disease or condition resulting in death) YEAR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine igned by the attending physician and be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nnknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes and No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospitaf: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No ≥ ER/Outpatient 3 DOA 1 Inpatient After this 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: the 3 🗌 Suicide 6 Could not be determined 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in To the Hospital **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0061564 physician 30. Name and ddress of person who con CATON Ave. BAltimore, MD 21229 900 10 31. Date filed (Month 32. Registrar's Signature State Registrar

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seorge

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 29672 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ′11, ٽُ2ُٰ̈ٺ05 Month Day September **Physician** Bernier, George Joseph III 5:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6413 Sefton Ave. Baltimore n/a If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F Days Hours Min 227-76-4451 Director 50 June 16. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location itam 27 is markad other than "natural", or itams 23a or 28a-1 show othar traumatic avant, the Madical Examinar must be nything all 10d. Inside City Limits 1 XYes 2 □ No Director n/a Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6413 Sefton Ave. 21214 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ White Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 72 th and Mental Hygiene. 7 is markad other than "ni College (1-4or 5+) Elementary/Secondary (0-12) Truck Driver Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Joseph Bernier, Jr. Ann L. Caravati 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) pernit. Pages 1 and 2 sh Dep.rtment of Health and Impc.rtant: If itam 27 is rr any njury or othar traum 000.66. Felicidad M. Bernier/wife 6413 Sefton Ave., Baltimore, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Parkwood Cemetery 09/14/2005 4 ☐ Ponation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Serve Licentee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Stephen Coster 1050 York Road, Towson, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LIVER Physician disease or condition resulting in death) MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, i any, learning to increase cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Tetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: Other: 4 Nursing Home P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Hesidence 6 Other (Specify) 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Natural s after dec. 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 D Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0007264 Cori a 30. Name and a dress of person who complete statuse of death (Item 23a) (Type, Print) Herpital Hophire 0720,12. TLANI) 31. Date filed (Month, Day, Year) SEP 13 32. Registrar's Signature State Registrar

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	To the To the Comp	Σ	29b. Signature and title of certifi	ar				29c	. License	number			29d. Da	ite signed	i (Month, E	Jay, Year)	
}			Daros ()	•			0	.C.M	.E.			Sept	tembe	er 8.	2005	
n	or		30. Name and address of persor			death (Item	23a) (Type,						~ C P		,	1005	
9)		ANA R	NBI	O, HD		111 Pe	enn St	treet	t, Ba	ltimo	ore, M	ary1a	and 2	21201		
	Sta		31. Date filed (Month, Day, Year)	32. Registr	rar's Signa	ture	<i>y</i>									
	Registr	ar	SEP 1	3 20	005	1300 3	K. A	BILL	,								
DHI	MH 17 Rev 1/2	001			OF THE STREET		1										

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

				State of W	aryland / De C	ertificate of	Death	Re	g. No.	05 296	57		
	Physici /Medio		Decedent's Name (First, Middle, L Russell Book	ast) oker	Bemis			2. Date of Death Month Sept. 1		3. Time of Dea 10:33pi			
	Examin		4a. Facility Name (If not institution, g				4b. City, Town, or Lo	ocation of Death	4c. County o	f Death			
-	Funeral		Charlestown Reti: 5. Social Security Number 6.		je (In yrs. last birthd	Months Davs	Hours Min.	8. Date of Birth (Month, Day,	Year)	timore 9. Birthplace (State or Fo	xreign		
	Director		002-10-8292	15 M 2 L F	7 Yrs			March 2,	1918	Massachuset	ts		
	pue M.		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Li	imits		
	f sho	ō	Maryland Baltimo	re.	Catons	ville				1 □ Yes 2√C	□No		
	288	Director	10e. Street and Number			10f. Zip Code		10	Og. Citizen of Wi	nat Country?			
	38 ol	<u>=</u>	709 Maiden Choi	ce Lane #	433	21229)		USA				
	death	Funerai	11. Marital Status	12. Was Decedent Armed Forces			Hispanic Origin? (Spo pan, Mexican, Puerto	ecify Yes or No-		- American Indian,			
Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health end Mental Hygiene. Depertment of Health end Mental Hygiene. Importents: if item 27 is marked other then *netural', or items 23e or 28e-f show any highty or other traumatic event, the Medical Examinar must be natified at once.	<u>م</u>	1 ☐ Never Married 2 ☐ Married 3 1 ☐ Widowed 4 ☐ Divorced	1 Yes 2 ☐ If Yes, Give Year or Dates:	No 1941–66	1 ☐ Yes 2 ☑ No		rtioan, etc.)	Specify:	, White, etc. White			
9	72 ho	et e	15. Decedent's I (Specify only highest g	Education	16a. De	cedent's Usual Occu	pation	ina	16b. Kind of Bus	iness/Industry			
7	en r	Completed	Elementary/Secondary (0-12)	College (1-4or	5+) \(\iif	e. DO NOT use retire	during most of work ed)	9					
2	ed w ygier yer th	ပ္ပ	12	2		Lt. Colone	1	- /5 A A A A A A A		Army			
Pu.	be fill d oth	Be	17. Father's Name (First, Middle, Las				18. Mother's Name	ə (First, Middle, N					
ž	J Mer J Mer narke	2	Eugene 19a. Informant's Name/Relationship	Bem (Time Print)		ailing Address /Strag	E11a	al Poute Number	Booker				
Ma	d 2 sl th end 7 is n traur		Valerie B. Marsh			-	ant Rd., N						
	1 an Heal em 2		20a. Method of Disposition	GII (2008	20h Place of Di	sposition (Name of	1			city or Town, State			
ē	ages ant of t: if it y or c		1 Burial 2 Cremation 3		Baltimo	rematory or other pla re Cremato	ory @	/14/05	Raltimo	re. Marvlan	ıd		
Baltimore,	nit. Pertme		202. Name and Address of Facility Loudon Park Funeral Home										
ä	Dep Imp any						ens Ave.,						
			23a. Part1-Enter the disease, or co- shock, or heart failure. List onl	mplications that cause	d the death. Do not	enter the mode of dy	ing, such as cerdiac	or respiratory arre	est,	Approximate Interval Between			
	Physician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in death)	Arten	Oscherolu Due to (or as a con		OVASCUL	Par de	isease	Onset and Deat			
V	rificete be executed ng physician end es the buriel-transit	Examiner	Sequentially list conditions,	b	Due to (or as a con	sequence of):			W-84.6				
60,	be ex ician buriel		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	C									
68760,	tificete ng phys es the	Medicai	that initiated events resulting in death) Last		Due to (or as a con	sequence of):				1			
Вох	eath cert ettending 1 for use	2		d						<u> </u>			
	deat	sicis	Part II. Other algnificant conditiona		out not resulting in th	e underlying cause g	iven in Part I.	23b. Did tol	bacco use cont	ribute to the cause of de	eath?		
P.0	that the de led by the e deteched f	Physician/	Prabelin	mellitu	Ho	af Bil	rillation	1 ☐ Ye	8 2 No	3 ☐ Probabiy 4 ☐ Unk	inown		
	res tha igned	۾	1/00			0				Odb. Mars autorou findin			
of Vital Records,	The law requires that the death celete has been signed by the ettendir	Completed				-		24a. Was ar perform		24b. Were autopsy findir available prior to completion of cause of death?			
E		S						1 □ Ye	s 20 No	1 ☐ Yes 2 ☐ No			
/ita	Physician: The la rthis certificete have ral director, pege 2	Be	25. Was case referred to medical examiner?	N I A-I			26. Place of Deat	h (Check only one	э)				
<u>}</u>	hysic this c	မ	1 Yes 2 No	Hospital: 1 ☐ Inpati		tient 3LI DOA		me 5 Reside					
	ling P	ioi.	27. Manner of Death 1 DNatural 5 □ Pending	28a. Date of Inju (Month, Da	ury Year) 28b. Tim Inju	y Wo	ork? ☐Yes 2☐No	28d. Describe ho	w injury occurre	u			
Division	or Attend fler death lirector: /	Certification:	2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be 28e. Place of In	jury - At home, farm, ic. (Specify)	street, factory, office		28f. Location (Str City or Town		r or Rural Route Number,			
	To the Hospital or Attending Ph within 24 hours efter death. To the Funerel Director: After th completely filled in by the funeral	edicai Ce	29a. Certifier 1 Certifying F	Physician: To the best aminer: On the basis of and manner st	f examination and/o	eath occurred at the t r investigation, in my	ime, date and place, opinion, death occurr	and due to the ca red at the time, da	use(s) and man ite and place, ar	ner as stated. nd due to the cause(s)			
	To the within:	Mec	29b. Signature and title of certifier	am i	Ø		nse number 2004			(Month, Day, Year)			
	10+1		30. Name and address of person who	o completed cause of	death (Item 28a) (Ty	pe, Print)	hour (are, c	aton	Welle, MA			
			31. Date filed (Month, Day, Year)	32 Benist	rar's Signature	1				2/22	16		

Registrar

SEP 1 3 2005 Sieur J. Aprile

			For State Registrar	State of Maryland / Dep	artment of Health and Natificate of Death	Mental Hygier		29675
	Physici /Medic		1. Decedent's Name (First, Middle, Las	But	Her	2. Date of Death	Day Year	3. Time of Death
	Examir 	er	4a. Facility Name (If not institution, give 250 3 Libert 5. Social Security Number 6. Security Number 6. Security Number 7. 6. Secur	Ave	Ballimore If Under 1 Year If Under 24 Hrs.		4c. County of Death NA 9. Birtho	lace (State or Foreign
	Director		Usual Residence of Decedent	□ M 2 \$ F 6/ Yrs.	Months Days Hours Min.	8. Date of Birth Month, Day, Yea	1944 Mam	place (State or Foreign http://www.
	the Maryla 28a-f shov	Director	10a. State 10b. County 10e. Street and Number	Balbin	nore			0d. Inside City Limits 1 SYYes 2 □ No
	eath with		2503 Violet	fue 12. Was Decedent Ever in U.S. 13.	10f. Zip Code 2/2/5 Was Decedent of Hispania Origin? (S		Citizen of What Coun	
900	hours after death with the Maryland tural', or items 23a or 28a-f show al Exanti wir minit be institled at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (St If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	Rican, etc.)	14. Race - Americ Black, White, Specify: Black	
21215-0036	within 72 ane. than "nai	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)	College (1-4or 5+) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	king 16b.	. Kind of Business/Ind	
Maryland 2	should be filed on the marked other imarked other imarked other imaric event, I	To Be C	17. Father's Name (First, Middle, Last)	utler	Managar 18. Mother's Nam Callsoff	e (First, Middle, Maid	_	he —
	nd 2 shullth and 27 is m		19a. Informant's Name/Relationship (7)	Son 222	ng Address (Street and Number or Ru.	al Route Number Cit		Code)
Baltimore,	L T of B		20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		osition (Name of matory or other place) Wast Comain 9-1	Date 20c.	Location - City or To	
Balt	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licen	Douglane 1	Name and Address Drilling Co.	L. Ball.	pld. 212	1.5.
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	olications that daused the death. Do not entropie cause on each line. a. Mutiple multiple	ter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner	j.	Sequentially list conditions	b. Due to (or as a consequence of): 7				
	cate be executed physician and the burial-transit	Examiner	Tany, leading to inhibidiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of):				
09289	ificate being physician	edical		d				
.O. Box	requires that the death certific neen signed by the attending p hould be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year
ords, P	w requires that been signed b should be deta	ξ	Part II. Other significant conditions of	ontributing to death but not resulting in the u	inderlying cause given in Part I.		o use contribute to th	
Vital Records,	The law ate has b page 2 s	Completed				24a. Was an autopsy performed 1 ☐ Yes 2Â1	prior to con death?	osy findings available inpletion of cause of No
of Vit	of is	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatier	Other	th Check only one) ome 5 Residence	6 □Other (Specify	')
Division o	ending sath. or: After he tune	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28b. Time o Injury	Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in		
Divi	i Diff o		4 Homicide determined	building, etc. (Specify)		City or Town, Sta	· ·	
	the Hospital hin 24 hours a the Funeral I npletely filled	edicai	29a. Certifier (Check only one) 1 Certifying Physical Exemption (Check only one)	ysicien: To the best of my knowledge, deat iner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as sta and place, and due to	ated. the cause(s)
	To the vithin To the comple	Σ	29b. Signature and title of eartifier	R. MORAN MID	29c. License number	29d. C	Date signed (Month, L	Day, Year)
,	31		30. Name and address of person who o	completed cause of death (Item 23a) (Type,	06054775 D-#208 Ton	Ican mi	2121	001
:	Sta		31. Date filed (Month, Day, Year)	32 egistrar's Signature	Dr. 108 10h	don mil	00100	7
	Registr	ar	SEP 1 3 20	UD RESERVED ST ASS				

State of Maryland / Department of Health and Mental Hygiener 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Nancy Lee Corcoran Sept 2005 01:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 700 Marianne Lane Catonsville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 💆 F 67 Director 217-34-9820 Yrs. Jan 2, 1938 Maryland Usual Residence of Decedent the Maryland show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits treumetic event, the Medical Examiner must be putified at Directo Maryland Baltimore 1 ☐ Yes 2 → No Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 700 Marianne Lane or Items 23g 21228 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ent of Health and Mental Hygiene. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Hairdresser Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Milton Hess Margaret V. Slacum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward T. Corcoran / Husband 700 Marianne Lane, Catonsville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Decimation 5X10ther (Specify) entombment Loudon Park Maus. 9/13/2005 Baltimore, Maryland Funeral Service Licensee 21. Ignati re 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Metastatic carcinoma of the lung 3 months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. signed by the a 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ hypertension 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2X No 1 Yes 2**X** No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 No P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of centil 21928 30. Name and address of pers who completed cause of death (Item 23a) (Type, Print) Leonel Barahona, 3459 St. John's Lane, Ellicott City, Md. 32. Registrar's Signature 31. Date filed (Month, Day, Year) SEP 1 3 2005 State Registrar

DHMH 17 Rev 1/2001

		Ragistrar 1. Decedent's Name (First, Middle, La	ast)	Cel	tificate of D	- Calli	2. Date of Dea			3. Time of Dea
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miner		la. Facility Name (If not institution, gir			4b. City, Town, or I	Location of Death			nty of Death	
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eral	5	5. Social Security Number 6.	Sex 7. Age (In yrs. I	ast birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth	1	9. Birth	place (State or For
tor	L	410-56-2544	1□M 2\F 69	Yrs.	Wortus Days	Hours Mitt.	June 2,	1936	Tenr	nessee
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N A		3 Widowed 4 □ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1☐ Yes 2 No	Specify:		Spe	city: Bla	ack
r, the wealtest ever	2	15. Decedent's E		16a. Deced	ient's Usual Occupat	tion	T-	16b. Kind of	Business/Ir	ndustry
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E O	5	Elementary/Secondary (0-12)	College (1-407 3+)	C	hild Care	Provide	r	Day	y Care	9
Be C		17. Father's Name (First, Middle, Las	1)			18. Mother's Nam	e (First, Middle,	Maiden Sum	name)	
To	5	Polk Jennins				Epsie B	rewer			
or other traumatic event, the Medical Evant and Fried for Interest of To Be Completed by Funeral Director		19a. Informant's Name/Relationship		19b. Mailin	ig Address (Street ar	nd Number or Ru	rai Route Number	, City or Tov	vn, State, Zi	p Code)
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e e	12	20a. Method of Disposition	1 00	ace of Dispo	sition (Name of natory or other place	j i	Date	20c. Locatio	n - City or T	own, State
ō <u>≻</u>		1 ☐Burial 2 ☐ Cremation 3 [1 ☐ Donation 5 ☐ Other (Special Control of the cont	THemoval from State		Park Sout	1	-2-05	Mem	phis,	TN
any injury		21. Signature of Funeral Service Lice	nsee	0 (4	. Name and Address Jef	of Facility				
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Vsic	701	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time or de 9☐ Unknown	atn 5	Other (specify)					,
v Physic	Ē,	Part II. Other significant conditions	contributing to death but not resu	lting in the ur	nderlying cause giver	n in Part I	23e. Did tol	nacco use co	antribute to t	the cause of death
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ion in	5 '	27. Manner of Death 1 Statural 5 ☐ Pending	(Month, Day Year)	28b. Time of Injury	Work		28d. Describe ho	w injury occ	curred	
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	5	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, rarm, str	eet, factory, office		City or Town	reet and Nu 1, State)	mber or Hur	al Route Number,
irtif		00. O. W								
illed in by the tuneral		29a. Certifier 1 ☐ Certifying P (Check only 2 ☐ Medical Exa	hysician: To the best of my know miner: On the basis of examinat	viedge, death ion and/or inv	n occurred at the time restigation, in my opi	e, date and place, nion, death occur	and due to the cared at the time, d	ause(s) and ate and plac	manner as s e, and due t	stated. to the cause(s)
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mpletely filled in by	edical	one)					2	9d. Date sig	neu (MONT).	
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ORIGINAL

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 29678 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year harles 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Ivy Hall Geriatric Center Middle River Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 6, 1920 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign **№** 2□ F West Virginia 236-42-6785 Yrs. Director 85 Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 7 is marked other then "neturel", or items 23e or 28a-f show treumatic event, the Medical Examinat must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 Yawmeter Drive 21220 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other then "neturel", or Ite 1349 1 ☐ Never Married XX Married Baltimore, Maryland 21215-0036 þ 1 Yes XXNo Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker Steel Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Cross Sympthy P. Kimble 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Importent: If Item 27 is any injury or other tre 1848 Emily Drive, Edgewood, Maryland 21040 Diane Peyton (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gard Sept. 12, 2005 Baltimore, Maryland ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ski Funeral Home, P.A. Local Sir & License 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part H. Erfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease o condition Physician b-SLS meele resulting in death) /Medical Due to (or as a consequence of) Examiner neumon Sequentially list conditions, if any, leading to immediate cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 1 Yes 2 No 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed certificate 2 1 ☐ Yes 2 ☐ No Yes the Hospitel or Attending Physicien: director 25. Was case referred to medical 26. Place of Death Check on ne examiner? Other: 4 Trursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1- Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours at To the Funerel D Descritiving Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who co pole ed cause of death (Item 23a) (Type, Print) Mace OKN -0/f 37 Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

William Craig 05-06195 RP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are L

Type of Frint in Black indelible ink.	Ensure All Copies Are Legible.
State of Maryland / Department of H	ealth and Mental Hygiene

PD			1 - State Registrar	Otate of Marytar		tificate of D			og. No. 20	05 2967
	Physici	an	1. Decedent's Name (First, Middle, La.	st)	0			2. Date of Deat Month	Day Ye	3. Time of Death
	/Media	al	4a. Facility Name (If not institution, give	m H	Cr	Al G	anation of Doubt	Septeml		005 0303 A ^M
af.	Examir	er	Sinai Hospital	e street and number)		4b. City, Town, or Lo Baltimore			4c. County of E	eath J
	Funeral		5. Social Security Number 6. S			If Under 1 Year		8. Date of Birth (Month, Day,	Vearl 9.	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	M 20 F 58	Yrs.	Months Bays	TIOUTS WINT.	Aug. 24		nanyland
	yland 10W		10a. State 10b. County	10c. Ci	ty, Town or Loc	ation		U		10d. Inside City Limits
	e Mar	ctor	md N	A		alten	nore			1) Yes 2□No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any Injury or other traumatic event, Its Modical Examinar must be notified at ances.	Funeral Director	10e. Street and Number 3214 5 09	uoir An	re	10f. Zip Code 2 2	-15	1	0g. Citizen of What	Country?
	r deat	ıner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. W	as Decedent of Hisp Yes, specify Cuban,	panic Origin? (Spec	offy Yes or No-	14. Race - A	merican Indian, /hite, etc.
2-0036	ours afte	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		- ~ /	Specify:	, 0.0.,	Specify:	Black
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aryland	should be nd Mental marked c	To B	Willie	Jame	8	_	Lillie	Belle	e Cra	iG
Jan	2 sho		19a. Informant's Name/Relationship (*	19b. Mailing	Address (Street and	d Number or Rural	Rou Number	City or Town, Stat	e, Zip Code)
ė,	1 and Health em 27		20a. Method of Disposition	- WIFE	Place of Dispos	ition (Name of	ir the	te	20c. Location - City	or Town State
altimore,	Pages nent of int: If It iry or o		1 Burial 2 Cremation 3 4 Donation /5 Other (Specific	Removal from State	cometery, crem Voodla	atory or other place)		-15	2 11	or rown, state
a E	permit. Pag Department Important: any Injury o		21. Signature of Juneral Service Licer	Mary Control of the C	_	Name and Address of	of Facility	, ,	Pass	1114.
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į	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a MULTIPLE	GUNS	HOT W	VOUNDS			Oriset and Death
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	ecuter and transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c						
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ita	clan: ertifica ector, p	Bec	25. Was case referred to medical examiner?			26	6. Place of Death			′es 2□ No
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lo	Attending Physician: If death. Sector: After this certifice by the funeral director, t	Certification:	1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year) 9110/05	28b. Time of Injury for 2:40 A	28c. Injury at Work? M 1 ☐ Yes	t 28	SVBTECT	w injury occurred	SHOT
Ν	F = -	rtific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre	et, factory, office		City or I own	. State)	Rural Route Number,
	pital o		CO. Cartina III Cartini B	STREET				sec sec	UCIA AVE, 1	BALTIMORE, MD
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best of my knoniner: On the basis of examination and manner stated.	owledge, death ation and/or inve	occurred at the time, estigation, in my opini	date and place, ar ion, death occurred	nd due to the ca d at the time, da	use(s) and manner ate and place, and	as stated. due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. License no	umber	29	d. Date signed (Me	onth, Day, Year)
.			> aues2			O.C.M. H	Ξ	S	September	10, 2005
	6		30. Name and address of person who	completed cause of death (Item		rint) enn Street	t, Baltim	ore, Ma	ryland 2	1201
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 3 20		ature for	de)				

DHMH 17 Rev 1/2001

Sports

		For State Registrar		State of Mary		ertificate of			giene Reg. No. 200	5 29680
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Direct		Usual Residence	of Decedent 10b. County BALTIN		or 9 Trs. Ic. City, Town or I	RKville	2	Dec. 6	, 1975 M	10d. Inside City Limits 1 Yes 2 No
ter deeth witi	by Funeral Director	10e. Street and No. 29/4 11. Marital Status	U; Hough	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	r in U.S. 13	. Was Decedent of If Yes, specify Cut		pecify Yes or No to Rican, etc.)		t Country? American Indian, Yhite, etc.
- s	Completed by	(Spe	4 Divorced 15. Decedent's Educify only highest grain ondary (0-12)	ucation	(Giv	edent's Usual Occu e kind of work done DO NOT use retire	pation during most of wo	rking	Specify: 16b. Kind of Busine BALTIMO	
Tarylan 2 should be and Mental 16 marked o	To Be	VERNO	(First, Middle, Last) A. H Name/Relationship	OPU ypo, Pint)	19b. Mai	ling Address (Stree	BARB	aRA A.	Maiden Sumame) Wa RNS. er, City or Town, State	te, Zip Code)
Iltimore, nit. Pages 1 ar artment of Hea ortent: If Item;	Ŕ	4 □Donation	sposition Cremation 3 Other (Specify uneral Service Licen	Removal from State	20b. Place of Disposemetery, ch	osition (Name of emato a 17-r p. 22. Name and Addr	PFT - 9-	17-05 AU TI MORE	20c. Location - City FOREST E, MD 21	Hill MIN
Physicia		tmmediate Cause disease or condit	(Final	dications that caused the cause on each line.	death. Do not en	VAUS FUNE nter the mode of dy	PAL CH ing, such as cardia	APEL 8	800 HARFO	
3760, at the second of the sec	icai Examiner	Sequentially list of any, resulting to cause. Enter Unc Cause (Disease of that initiated even resulting in death)	onditions, minediate ertying r injury ts	b. Due to (or as a co	o isequence of).					5.0 [5.1.]
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cords, P.	þ	Part II. Other sign	ificant conditions or	ontributing to death but no	ot resulting in the	underlying cause gi	ven in Part I.	23e. Did to		e to the cause of death? Probably 4 □Unknown
Vital Recolcion: The law reconflicate has be rector, page 2 sho	e Completed	25. Was case refe	arred to medical					1 ☐ Yes	osy prior rmed? deatl 2 No 1	e autopsy findings available to completion of cause of h? Yes 2 No
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Divisio To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A	cai Certifi	4 Homicide 29a. Certifier (Check only	determined	28e. Place of Injury building, etc. (S	Specify)	eth occurred at the t	emos ofasto acced colano	City or Tov	vn, State)	r Rural Route Number,
To the H within 24 To the F	Medical	29b. Signature an	d title of certifier	and manner stated.		29c. Licen	se number		29d. Date signed (M	onth, Day, Year)
OCK 10 -1	State istrar	Willian		15753 KM	Falls Rd Signature	100 H415 (Lithrelle,	Md, 2100	13	-

State of Maryland / Department of Health and Mental Hygiene 2005 29681 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Willie September Lause 1803 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University Manyland Medical System
6. Sex 7. Age (In yrs. last birthday) BALTIMORE of 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 9860 Days 1 M 2 F Months Hours Min 348 20 **Director** SOUTHEARDLING Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location er than "natural", or Items 23a or 28a-f ehow . Ite Medical Examiner must be notified at 10d. In side City Limits 1 Yes 2 No Director HARFORD CHERTERO FOREST 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? . (-21050 1202 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

↑ DYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No à Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced STIKE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7/ th and Mental Hygiene. 7 Is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) ·4R.15 127RS GETHLE HEM 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be AUSIX SPILA honnis 707UFK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n eny injury or other traun 900. 5LVIRA 1505BRADEH 1 JARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State AiRY 4 □ Qonation 5 □ Other (Specify) 12m. GARDINS BOOK 22. Name and Address of Facility, HAPE 21. Signature of Funeral Service Licens Air PA. BLI EVANSTURGICHE 21030 43 FOREST 23a. Part1. Enter the disease, or comp shock, or heart failure. List only olications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** pulmonan fibrosis 30 years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its and on the cause). Due to (or as a consequence of). Examine The law requires that the death certificate be executed burial-transit been signed by the attending physician and should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 1 ☐ Yes 1 🗌 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this After thi 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 2 Accident 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funerel Director: completely filled in by the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) geronit a May In, MD P17646 Sept. 09, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JENNI FER A . TAYOR , MD 22 SOUTH GREENE BACTIMORE STALE? MARYLWO 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 2005 Registrar 1

Amend item#26, per Mi, G847, 19/20/05 IT State of Maryland / Department of Health and Mental Hygien 2005 29682 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 11:44 P M Dorothy Laura Calkins September 10, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brightview Assisted Living Bel Air
If Under 1 Year | If Under 24 Hrs. Harford 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🖫 F 87 Yrs. Director 212-05-0168 16, 1918 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5 300 Ring Factory Road 21014 Iteme 23a USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify 3X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ George Edwin Yeagle Mary Madeline _Spath 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other trat <u>once.</u> Richard Alan Calkins / Son 11 Linwood Court, Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Grdns 9-14-05 Bel Air, Maryland McComas funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part i Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardio disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** pertorata Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ny 1 Pas Examine attending physiclan and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate hes tirector, page 2 s autopsy performed 1☐ Yes 2 XNo 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner reing Home 5 Residence 6 Nother Specified Living Other: 1 ☐ Yes 2 **X** No Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending М 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: / 6 Could not be determined 3 Suicide 28e. Place ol Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funeral Direct completely filled in by t 4 Thomicide 🏗 Certifying Physician: To the best ol my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number u am 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) o un 31. Date liled (Month, Day, Year) 32. Registrar's Signature State

Registrar

2005

		Registrar		laryland /	Cen	tificate of	Dealli			Rag. No.		
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miner		ta. Facility Name (If not institution, gi	oad			4b. City, Town, o	od		-	Н	ounty of Death	
or		,	Sex 7. A(1 M 2	ge (In yrs. last 65	Yrs.	If Under 1 Year Months Days		Min.	8. Date of Bir (Month, Da NOV • 8	193	9 Gerr	nplace (State or Foreig untry) Many
Director		Maryland Harfo	ord	10c. City, To	own or Local	d						10d. Inside City Limit
al Dir		713 Bayberry Ro	oad			10f. Zip Code 2104	0			10g. Citize	on of What Coi USA	untry?
by Funeral	<u>ک</u> ا	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 25 If Yes, Give Year or Dates:	?		/as Decedent of H Yes, specify Cub			cify Yes or No Rican, etc.)		I. Race - Amer Black, White Specify:	rican Indian, a, etc. White
Completed	mpieted	15. Decedent's E (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-4or	5+)	(Give ki life. Di	ent's Usual Occup ind of work done O NOT use retire	during mos	at of worki	ng		d of Business/l	ndustry
B C	e a	17. Father's Name (First, Middle, Las	eber		Cashi	er		er's Name	(First, Middle		umame)	vernment
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	-	23a. Part1. Enter the dise see conshock, or heart failure. List only Immediate Cause (Final disease or condition	plications that cause y one cause on each I	d the death. C	Do not enter	317 COKe r the mode of dyin	ng, such as	y Roa cardiac o	d, Abi	ngdon	, Mary]	Approximate Interval Between Onset and Death
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DHMH 17 Rev 1/2001

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			1 - For State Registrar	State of Ma	arylan				lealth a Death		-	giene Reg. No.	005	29684
100	1000		1. Decedent's Name (First, Middle, L.	ast)							2. Date of De		Vana	3. Time of Death
	Physicia			Michael	Lar	nier	Deni	nis			Month 9	Day 6	Year 2005	3:22 p M
	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and number)			4b. Cit	, Town, or	r Location o	of Death		4c. (County of Dea	
	E Admin		St Agnes Hospi	tal			Ba	Lto				N	/A	
	Funeral			Sex 7. Ag	e (In yrs. I	last birthday)	II Und	er 1 Year	If Under		8. Date of Bir	th	9. Bi	rthplace (State or Foreign
	Director		212-15-0926	1 2 M 2 □ F	27	Yrs.	Months	Days	Hours	Min.	(Month, Da 10-5-1	-		ountry) Md
Mari	-0.11		Usual Residence of Decedent					1						110
	Name Name		10a. State 10b. County		10c. City	y, Town or Lo	ocation							10d. Inside City Limits
	Mar	to	Md	N/A	Ba1	to								Yes 2□No
	288	Director	10e, Street and Number				10f. Z	ip Code				10g. Citiz	en of What C	ountry?
	3a o		7027 Brompto	n Road				2	1207			II	S A	
	i witin 72 hours after death with the Maryland igne. Then "naturel", or iteme 23e or 28e-f ehow in the Medical Eracult et mult be notified at	Funeral	11. Marital Status	12. Was Decedent	Ever in U.	S. 13.	Was Dec			gin? (Spe	cify Yes or No lican, etc.)		4. Race - Am	erican Indian,
	Ter in	F	1 XNever Married 2 Married	Armed Forces?	No		If Yes, sp	ecify Cuba	an, Mexicar	n, Puerto P	Rican, etc.)		Black, Wh	ite, etc.
ລັ	a 'i'	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 🗌 Yes	2 ∑ No	Specify:				Specify:	lack
2-003c	72 hours after naturel', or Ite		15. Decedent's f	Education		16a. Dece	dent's Us	ual Occup	ation			16b. Kir	id of Busines	
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7	within ene. then "	Completed	Elementary/Secondary (0-12) 12th grade	College (1-4or 5	N/A		Truc	k Dr	iver			Cupi	car on	reduring Co.
D .	be filed tal Hygi d other event, I		17. Father's Name (First, Middle, Las	st)	21,22		11.00	I DI		er's Name	(First, Middle	, Maiden :	Sumame)	
	o la la po	Be	Claude J. Denni						Barb	ara R	Rudisil	1		
5	should nd Men marke umatic	ို	19a, Informant's Name/Relationship			10b Maili	na Addra	cc /Street			Route Numb	=	Tour State	Zin Code)
<u>g</u>	C/ C/ = 8			Par	ents									210 0000)
	l and Health Im 27 Iner ti		Claude & Barbara 20a. Method of Disposition	Dennis-	20h P	lace of Dispe			Road		to, Md			r Town, State
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saitimore,			4 ☐ Donation 5 ☐ Other (Spec	ify)	Dru	id Ric	dge (emet	ery				to, Md	
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4.	4		23a. Part 1 Enter the disease, or co shock, or heart failure. List on	mplications that caused	the death	h. Do not en	ter the m	ode of dyin	ng, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between
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	/Medical		disease or condition resulting in death)	a Due to (or as	a consed	neuce ot).		m ca	- 1	A		1	1	31000
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e ×	eath certific attending p	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregna	ancv							24 D-114	C
Box	death of attended tor us	an	23b. Was decedent pregnant in the past 12 months?	1□Live birth 4□Pregnant a	2 Feta	I death 3	□Ectopic □ Other (pregnancy	У			-	3d. Date of de Month	Day Year
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ř	The la	E									perfo	ormed?	death?	
ā		· e	25. Was case referred to medical	T					26. Place	e of Death	(Check only			20.00
5	nysiclen: nis certitice I director, p	To B	examiner?	Hospital:	ent 2	ER/Outpatie	ent 3 🗆	DOA Oth			ne 5 Resi		□Other (Sn	ecifu)
ō	Phy oral c		27. Manner of Death	28a. Date of Inju		28b. Time		28c. Injur Wor			8d. Describe			oony
0 0	ding h. h. Atter funer	ţ	1 Natural 5 ☐ Pending 2 ☐ Accident investigat		y Year)	Injury	М		rk? ∣Yes 2.∐	No				
Division of Vital Records,	Attending Physicien: r death. sctor: Atter this certitic by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not	be 290 Place of In	jury - At h	ome, larm, si	treet, lact	orv. office		2	8f. Location (Street and	d Number or I	Rural Route Number,
<u>≥</u>	etter Olred In by	ert	4 ☐ Homicide determine	building, et	c. (Specif	(y)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or To	wn, State)		
_	Hospitel or Attenv 14 hours elter deatl Funeral Director: tely tilled in by the		29a. Certifier 1 Certifying	Physician: To the best	ol my kno	wledge dea	th occurr	ad at the til	me date ar	nd place a	and due to the	Called(e)	and manner	ac stated
	표 쏚 때 후	Medical		aminer: On the basis of and manner st	f examina									
	To the within 2 To the Comple	Mec	29b. Signature and title of certifier	AND MAINTEN SI			- 1:	9c. Licens	se number			29d. Date	e signed (Mo	nth, Day, Year)
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0	1		Hadin	U.	711	,		100	1061	^			17/2	015
1) "		30. Name and address of person wh	o completed cause of o	death (Iter	n 23a) (Type	Print)	JUL	+6241	2	11.	- 1		
			21 Date filed (Marth Day Vord	9	233	// -	COL	vert	3/	D	alto, r	44		
	St. Regist	ate	31. Date liled (Month, Day, Year)	3 2005	els signa	A L	5000							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 29685 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day GEORGE L. DOYLE 6:41 PM SEPTEMBER 11, 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10/28/1930 9. Birthplace (State or Foreign **Funeral** 1XM 2□ F MARYLAND 212-26-6004 Director 74 Usuel Residence of Decedent 10a. State 10c. City, Town or Location ir then "naturel", or Iteme 23e or 28e-f ehow the Medical Examiner must be notified at 10d. Inside City Limits Director BALTIMORE PARKVILLE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8734 LACKAWANNA AVENUE 21234 e filed within 72 hours after death if Hygiene.
other then "naturel", or Iteme 23. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: KOREAN 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) METAL SALES 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H lant: If Item 27 is marked other JOHN C. DOYLE FLORENCE K. CRUMBACKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HELEN T. DOYLE/WIFE 8734 LACKAWANNA AVE. PARKVILLE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ò 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If eny injury or once. MORELAND MEM. PARK 9/14/2005 HILLENDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, 8521 LOCH RAVEN BLVD. TOWSON, 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death HOURS Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? VIRAL ENCEPHALITIS 1 Yes 2 X 3 Probably 4 Unknown URINARY RETENTION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 1 Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1X Natural 5 Pending Injury investigation 1 Tyes 2 No 2 Accident

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been accounted to the Funerel Director: Box 68760, o σ. Records, Division of Vital the filled in by Medical completely

154

CUNNINGHAM. 31. Date filed (Month, Day, Year) State SEP 1 3 2005

29b. Signature and title of certifier

3 Suicide

29a. Certifier

4 Homicide

M. D. OSLER DRIVE, TOWSON, 7601 82. Registrar's Signature

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MARYLAND 21204

29d. Date signed (Month, Day, Year)

6 Could not be determined

30. Name and address of person who completed cluse of death (Item 23a) (Type, Print)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 39215

State of Maryland / Department of Health and Mental Hygiene 2005 1 - For Stata Registrar 29686 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** John J. Drehoff 2005 /Medical Sep. 8. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 75 Milburn Circle Pasadena Anne Arundel 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday, If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Hours Min. 1√3 M 2□ F Director Yrs 216-16-2232 82 Aug. 17, 1923 Maryland Usual Residence of Decedent with the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "naturel", or Items 23a or 28a-f show Director 1 Yes 2 No MD Anne Arundel Pasadena 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 75 Milburn Circle Pages 1 and 2 should be filed within 72 hours after death 1 nent of Health and Mental Hygiene. Int: If item 27 Ie marked other then "naturel", or Items 23 21122 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2√□ No Specify: ģ Specify: white white 3 ☐ Widowed 4 ☐ Divorced Completed th and Mental Hygiene.
7 le marked other then "natur treumatic event, tre Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <u>Mechanical Engineer</u> BG&E 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John J. Drehoff 2 Myrtle Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other tre Once. Paul A. Drehoff- son 315 Hampton Rd. Linthicum, Maryland 21090 20b. Place of Disposition (Name of 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State Date 20c. Location - City or Town, State Loudon Park Cemetery Sep. 12, 2005 Baltimore City 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licen 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 Part. Enter the disease, or complications that caused a death. stock, or heart failure. List only one cause on each be. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner nysician and he burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, been signe should be c ģ 3 Probably Be Completed 1 ☐ Yes 2 ☐ No 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 2/2No 1 Yes or Attending Phyelcien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funerel Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and little of certifier 29c. License number Name and address of person with completed cause of death (Item 23a) (Type, Print) De luce 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Physician 09 07 2005 ETHEL ARVILLA DUNN 10:30 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BON SECOUR BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 F 212-22-2571 91 JUNE ŃС 14 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County f Health and Mental Hygiene. Item 27 ie marked other than "natural", or Items 23a or 28e-f ehov other traumatic event, the Medical Exertinar must be notified at 1 ☐ Yes 2 ☐ No Director MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code With 1541 N. FULTON AVENUE 21217 USA permit. Pages 1 and 2 should be filled within 72 hours efter death Department of Health and Mental Hygiene. importent: If Item 27 ie marked other than "natural", or Items 23-eny injury or other traumatin Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □ Yes 2 □ No If Yes, GiveX 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: BLACK Specify. 3 XWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MACHINIST CLOTH COMPANY 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) CHARLIE HUDSON CLARA EDWARD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) GENEVA LEWIS/SISTER 2028 N. PULASKI ST., BALTO., MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 9/16/05 KING MEM. PK BALTO., MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., 21 Signature J Funeral Service Ligenses BALTIMORE, MD 21217 hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a Part1. Enter the disease, or complications shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final Tens Pnysician disease or condition resulting in death) /Medical Due to (r s a consequence of): Examiner rdion Sequentially list conditions, Completed by Physician/Medical Examiner Due to (or as a consequence of cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed burial-transit 00 that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, as the IF FEMALE: **BSI** 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Day Year detached for 4 Pregnant at time of death 5 Other (specify) Yes 2 2 No Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 2 No 2 No 1 Yes 1 Tyes Division of Vital To the Hospitel or Attending Physicien: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: Hospital: 1 Yes 2 No within 24 hours efter death.

To the Funerel Director: After this c completely filled in by the funeral directors. 1 Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification; Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 2 Medical Examiner: 29c. License number 29d. Date signed (Month, Day Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 MUEURA Common wealth Willie 413 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	aryland / De _l	oartment e <i>rtificate</i>	t of H e <i>of L</i>	ealth a D <i>eath</i>	and M	ental Hyg	giene 20	05	29688
			1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physici /Medic		Patricia A. De	raw						Septemb		2005	11:30P M
	Examin		4a. Facility Name (If not institution, give					Location of	of Death		4c. County		
			214 Sipple Avenue			Ful1			A711 T			/A	
	Funeral Director		210 32 2330	7. Ag	e (In yrs. last birthda 69 Yrs.	y) If Under Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day 6/28/19	936	Coul	place (State or Foreign htry) -yland
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location							I Od. Inside City Limits
	e Maryli	ctor	MD N/A			erton							1 √X es 2□No
	n with th	ai Dire	10e. Street and Number 214 Sipple Avenue	2		10f. Zip		21236		-	10g. Citizen of V U • S	Vhat Cou	ntry?
336	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f ehow or other traumatic event, the Medical Examinat must be notified at or other traumatic event, the Medical Examinat must be notified at	by Funeral Director	11. Marital Status 1 Never Married 28 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		3. Was Deced If Yes, spec		spanic Ori n, Mexicar Specify:		cify Yes or No- Rican, etc.)	Blac	e - Americk, White,	
21215-0036	in 72 hou n "nature Wedical E	Completed	15. Decedent's Edit (Specify only highest grad	cation le completed) College (1-4or 5	(Gi	cedent's Usua ve kind of wor v. DO NOT us	rk done o	turina mos	t of workir	og	16b. Kind of Bu	ısiness/In	dustry
212	d with giene er tha	mo:	Elementary/Secondary (0-12)	2		trepre	neur				Self E	np1oy	zed
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Maryland	th and N		19a. Informant's Name/Relationship (T) Floyd DeGraw /Hus			-					r, City or Town, Maryla		
ē,	Hea Hea Hem Stem		20a. Method of Disposition	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	20b. Place of Dis		ne of			ate	20c. Location -		
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Baltimore,	permit. Pa Departmen Important: any injury		21. Signature of Funeral Service License			22. Name an	d Addres				ppel Fu e, Mary		Home Inc. 21206
	Physician		23a. Parl . Enter the dise se a mp shock, or heart failure. List only o Immediate Cause (Final disease or condition	ne cause on each li	the death. Do not			ı	cardiac o	r respiratory ari	rest,		Approximate Interval Between Onset and Death
8760, ^	/Medical Examiner bhysician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Cause and the cause that initiated events resulting in death) Last	b. Due to (or as	a consequence of): a consequence of):	Con, ta	210	4 :					1989
O. Box 68	death certifi e attending id for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregrant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death	3 □Ectopic pr 5 □ Other (sp					23d. Dat Mo	e of deliventh	ery Day Year
4	200	d by Ph	Part II. Other significant conditions co	ntributing to death b	out not resulting in the	underlying c	ause give	en in Part I					he cause of death?
Records,	The law ate has b page 2 sl	Completed								24a. Was a autop perfor	med?	death?	opsy findings available impletion of cause of
Vital	ician: Th certificate rector, pag	Be (25. Was case referred medical examiner?						of Death	(Check only or	ne)		
of V	Physician: this certific ral director,	P_C	1 ☐ Yes 2 Ø No	Hospital: 1 ☐ Inpatie				4 140			ence 6 Oth		(y)
ion	Attending P r death. ector: After t by the funera		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	y Yea <i>r</i>) 28b. Time y Yea <i>r</i>) Injur		8c. Injury Work	rat <br Yes 2□		8d. Describe h	ow injury occurr	ed	
Division	Dir	Certification:	3 Suicide 6 Could not be determined	28e. Place of In building, et	ury - At home, farm, c. (Specify)	street, factory	, office		2	8f. Location (S City or Tow		er or Rura	al Route Number,
	e Hospital 124 hours a e Funeral letely filled	Medical (29a. Certifier 1 Certifying Phyone) 2 Medical Exam	sician: To the best iner: On the basis o and manner st	of my knowledge, de f examination and/or ated.	eath occurred investigation	at the tim , in my op	ne, date an pinion, dea	nd place, a	and due to the ded at the time, o	ause(s) and ma date and place,	nner as s and due to	tated. o the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	,		290	DU	number 479	73	2	29d. Date signed	(Month,	Day, Year)
-	12		30. Nameyand address of person who c	ompleted cause of c	death (Item, 23a) (Typ	pe, Print)	1 1	h		Set	MA	77	17.7.7
	Sta Regist		31. Date filed (Month, Day, Year)	32. R	ar's Signature	Annak!	2	- (1-01	("11)		1000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 29689 1 - For Stete Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPT. 8, 2005 **Physician** 6:55 Ам JOHN W. DZIENNIK /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GENESIS HERITAGE CENTER DUNDALK BALTIMORE If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1√2 M 2□ F Months Yrs. 87 Director 215-03-4043 01/19/1918 MD. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 Yes 2 No BALTIMORE MD. N/A Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 331 HORNEL STREET 21224 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1941-1 Never Married 2 Married GYes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: by. Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 1945 "neturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) RAILROAD 10TH LABORER permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Importent: If item 27 is marked othe eny injury or other treumetic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JULIA KOZLOWSKA JOHN W. DZIENNIK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BALTIMORE, MARYLAND 21224 ROSALIE DZIENNIK/WIFE 331 HORNEL ST., 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State HOLLY HILL MEMORIAL 9/10/2005 BALTIMORE, MARYLAND * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenser Charles ZEILER + Dins 6224 EASTERN AVE 23a. Part1. Enter the disease, or ship shock, or heart failure. List only o Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line CINOM **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the deriving Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Cher (specify) the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown PULMONAR 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospitel or Attending 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 T Homicide within 24 hours a To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
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State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

((tom 2001) TYPE Print) A RITCHIE HIGHWAY BALTIMORE
MARYLAND, 21225

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** SEPTEMBER 8,2005 11:08A M Ida Marie Ehrlich /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Baltimore Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Nov. (Month Day, 1925) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F MaryTand Yrs. Director 79 213-20-7660 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov other traumatic event, the Medical Examiner must be notified at Directo 1 ☐ Yes 文文 No Catonsville Baltimore MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ò permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Haaith and Manial Hyglene. Important: If Item 27 is marked other than "natural", or itema 23a any injury or other traumatic event, the Mantana event, and once. 407 Montemar Ave. 21228 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married white 1 ☐ Yes 2₺ No Specify: White Specify: 3√Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Coordinator Volunteer Services State Of MD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John F. Shine Marie Gerstel ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond J. Ehrlich- son 4110 Ravenhurst Circle Glen Arn, Maryland 21057 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Baltimore Crematory Loudon Park 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Sep. 11, 05 BAltimore City 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Loudon PArk Funeral Home 21. Signatur of Funeral Service 3620 Wilkens Ave. BAltimore, Maryland Part1. Enter the disease, or complications shock, or heart failure. List only one causy mplications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** VENTRICULAR FIBRILLATION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ACUTE MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit . CORONARY ARTERY DISEASE that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as the IF FEMALE. 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown ANOXIC ENCEPHALOPATHY 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♣ No RESPIRATORY FAILURE page 2 autopsy performed? certificate 2 No 1 Tes director, 25. Was case referred to medical 26. Place of Death | Check only one 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending death. investigation 1 Tes 2 No 2 Accident after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a o the Hoapital 29a. Certifier Medical completely (Check only onel

Division of Vital Records,

P.O. Box 68760,

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO - W-05 MThicam D 31826 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD LINTHICUM, M. D. 7601 OSLER DRIVE TOWSON MARYLAND 21204 32. Bigistrar's Signature 1 3 2005 ORIGINAL

State Registrar

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene $2\,0\,0\,5$ 29691 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year UTHER EPPES 1240 P M September 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 232 OAK STREET TURNER STATION BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1፟፟M 2□ F Director Yrs 216-54-1426 54 FEB. 5, 1951 MD Usual Residence of Decedent with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examinar must be notified at BALTIMORE TURNER STATION Director 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 232 OAK STREET 21222 USA Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. nnt: If item 27 is marked other than "natural", or Itel 1 Nes 2 No If Yes, Give 1972/73 Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 LABORER U.S. POST OFFICE and Mental Hygie is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LUTHER EPPES, SR. BERTHA SEAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai <u>once.</u> FRANCES HENRY/AUNT 103 CENTER PL., APT. 105., DUNDALK, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) CROWNSVILLE VET CEM 9/14/05 CROWNSVILLE, MD 21/ Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST., BALTO., MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a Hypertensive Arterioscleratic Candiovascular Di sease Pnysician 10 years resulting in death) /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, it ally, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No autopsy performed? Yes 2 No certificate Division of Vital 1 Yes Hospital or Attending Physician: Be (25. Was case referred to medical 26. Place of Death Check onlone Other: 4 Nursing Home 5 Nesidence 6 Other (Specify)

28b. Time of 28c. Injury at 28d. Tescribe how injury occurred examiner? 2 1 ¥es 2 □ No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: After 1 Natural 2 Accident 5 Pending death. 1 □ Yes 2 □ No after death. investigation 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide in 24 hours the Funeral Dire 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as states.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) within 2 To the To the 29d. Date signed (Month, Day, Year) 018667 September 10, 2005 5+1 30. Name and address of person who completed cause of death (em 23a) (Type, Print) Lo Trimble Hill CT. Lutherville, Maryland 21093

DHMH 17 Rev 1/200

State Registrar

P.O.

		1 - For State Registrar	State of Man	yland / Depa <i>Ce</i>	artment rtificate	of He	ealth ai <i>eath</i>	nd Mental Hy	/giene Reg. No.	005	29692
Physici /Medic		1. Decedent's Name (First, Middle, Last) Thomas Ear						2. Date of D Month SEPT	eath		3. Time of Death 9:45a M
Examir		4a. Facility Name (If not institution, give str 6232 Laurelton Ave	eet and number) PNUC			ltim	ore			unty of Death	
Funeral Director	DEC 10	5. Social Security Number 226-30-7354 6. Sex	7. Age (li	n yrs. last birthday) 74 Yrs.	If Under 1 Months I	Year Days	Hours	8. Date of B Min. (Month, D JAN 24	rth ay, Year) , 1931		olece (State or Foreign htry) ginia
the Maryland 28a-1 show	ector	10a. State 10b. County Maryland N/A 10e. Street and Number	10	Oc. City, Town or Lo	Baltin				10- 00-		0d. Inside City Limits 1 X Yes 2 □ No
th with 1	ai Dir	6232 Laurelton Ave	enue		10f, Zip C	ode	212	14	Tog. Citizen	of What Cour	ntry?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Department of Health and Mental Hygene. Important: If ten 27 ie marked other than "natural", or iteme 23a or 28a-1 show imply journ other traumatic event. In Medical Exattr an must be maillied at once.	by Funeral Directo	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Eve Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: K		Was Deceder f Yes, specify		panic Origi Mexican, Specify:	n? (Specify Yes or N Puerto Rican, etc.)		Race - Americ Black, White, ecify:	
21215-0036 ad within 72 hours af gliene. or than "natural", or the Medical Exert.	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)		(Give	dent's Usual (kind of work DO NOT use	Occupati done dui retired)	ion ring most o	of working		of Business/In	ŕ
laryland 212 2 should be filed with and Mental Hygiene. ie marked other that aumatic event, that	To Be C	17. Father's Name (First, Middle, Last) Frank Everette				1		s Name (First, Middle 1a Hicks			
Mar nd 2 sho alth and 27 ie m		19a. Informant's Name/Relationship (Type Denise Everette/dau		1				or Rural Route Numb nue Balt:			
Saltimore, Maryland befile beful. Pages 1 and 2 should be file bearment of Health and Mental Hymportant: If tem 27 is marked oth my injury or other traumatic eventine.		20a. Method of Disposition 1 Burial 2 ACremation 3 Rer 4 Donation 5 Other (Specify)	noval from State	20b. Place of Dispo cemetery, cres Metro Cre	sition (Name natory or othe	of er place)		Date	20c. Locati	on - City or To	own, State
Baltimo permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Licensee Dawn F. McDo	glinald		$99 \text{ Fr}\epsilon$	eder:	ick R	ty of Mary	imore,	Inc. MD 212	.28
Physician /Medical		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one firmediate Cause (Final disease or condition resulting in death)	cause on each line.	Car		, .		lidiac or respiratory a	arrest,		Approximate Interval Between Onset and Death
Examiner	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	Shsequence of).	-						-
O. Box 6 ne death certifiing the attending prined for use as	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic preg				23d.	Date of delive Month	ery Day Year
cords, P. (w requires that the been signed by should be detac	þ	Part II. Other significant conditions contr	buting to death but n	ot resulting in the u	nderlying cau	se given	in Part I.		tobacco use d		ne cause of death?
	Completed							24a. Was auto perfe 1 □ Yes		b. Were autoprior to condeath?	psy findings available inpletion of cause of
Vital Fysician: The scentificate director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No	spital:	2 ☐ ER/Outpatier	t 3 DOA	Other:		Death Check only	one) dence 6 🗀	Other (Specifi	()
Vision of Vital Attending Physicien: T death. ector: After this certifica	Certification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Ye	28b. Time of		Injury a Work? 1 \(\text{Ye}		28d. Describe	how injury oc	curred	
DIVI:		4 Homicide determined	28e. Place of Injury building, etc. (S	- At home, farm, str Specify)	eet, factory, o	office		28f. Location (City or To	Street and Nu wn, State)	imber or Rura	l Route Number,
Divisio To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai	29a. Certifier 11 Certifying Physic (Check only one) 12 Medical Examine	ian: To the best of mr: On the basis of exa and manner stated	amination and/or in	estigation, in	my opin	nion, death	place, and due to the occurred at the time,	cause(s) and date and place	manner as st ce, and due to	ated. the cause(s)
To the within 2 To the comple	Σ	29b. Signature and title of certifier Devillam	Benedict.	he		icense n	number 5 85	\$ 7	29d. Date sig	ned (Month, I	Day, Year)
		,			Print)	,	J 03	A	1110	103	
Sta Registr		31. Date filed (Month, Day, Year)	Deted cause of death DICT, /S 32. Registrar's	Signature	THIS V	ALK	31.,	YDACTIM	SALE, M	1D 2(1	17.4/20

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2 0 0 5

			State of Maryland / Department of Health and I Certificate of Death		giene 20	05 29693
			Decedent's Name (First, Middle, Last)	2. Dete of Dec	eth Dev	3. Time of Death
	Physicia /Medic		Bernard A. Friend, Jr.	09	O8	05 2:154M
Ì	Examin		46 Fecility Neme (If not institution, give street end number) KESWICK NUrsing Home 46. City, Town, or I Balt	Location of Death	4c. County	of Deeth NIA
,	Funeral Director		5. Social Security Number 6. Sex 154 $\frac{1}{2}$ 6. Sex 154 $\frac{1}{2}$ 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birt (Month, De	y. 1928	9. Birthplace (Stete or Foreign Country)
	end **	-	Usuet Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mary	ট্	MD NA Baltimore			1 X Yes 2 □ No
	frer deeth with the Marylen ritems 23a or 28a-f show aner must be notified at	Funeral Director	10e. Street end Number 2153 Chelsea Terrace 10f. Zip Code 21216		10g. Citizen of V	Vhat Country?
	eeth 234	erai	11 Mas Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (S	specify Yes or No	- 14. Race	e - American Indian,
020	0 5	Ď	Armed Forces? 1 Never Married 2 Merried 1 Yes, Give 3 Widowed 4 Divorced Armed Forces? 1 Yes, Give 1 Yes, Give 1 Yes, Give 1 Yes, Give 1 Yes, Give 1 Yes, Give 1 Yes, Give	to Rican, etc.)	Blac	: Black
Ω Ω	72 hours "naturel", adical Ex) te	15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of work done	rking	16b. Kind of Bu	isiness/Industry
Baltimore, Maryland 21215-0020	d within right	Completed	12th grade 8 years Teacher			. City Schools
land	e d a b	To Be	The following the state of the	ne (First, Middle, e) May		е)
lary	d 2 should th end Mer 7 is marke traumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru	urel Route Number	er, City or Town,	State, Zip Code)
≥,	E E 2 F		Elizabeth B. Friend/Wife 2153 Chelsea Terral	Date		City or Town, State
201	or oth		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	09.15.05		
Ħ	permit. Peges 'Department of H Important: If Its any Injury or of once.		21. Singleture of Funeral pervice placesee 1 22. Name and Address of Fecility Valuation C. Greene			
æ	Pen Pen Pen Pen Pen Pen Pen Pen Pen Pen		Mun Williams SISTBaltimore N	ational	Pike B	alto. MD 21229
			23a. P. 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac strick, or heart failure. List only one ceuse on each line.			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final	(a		Vosas
	Examiner		Immediate Cause (Final disease or condition resulting in death) a. Congestive heart failure to consequence of):	-		- Jane
	P #	Iner				
	sete be executed bhysician and the burial-transit	Examiner	Sequentially list conditions, if any, teeding to immediate			
8760,	sician bouria		if any, teeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events Due to (or es e consequence of):			1
Φ	ing phy e as th	Physician/Medical	resulting in death) Last			
Вох	death certific e attending p ed for use as	lan	0.			
o.	υ ψ χ	hysic	Part tt. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did	5	atribute to the cause of death? 3 Probably 4 Unknown
ري ح	es thet igned b	by P	acute rend Salure, hypotic encephologoty	y	7(
Records,	requir been s should	Completed			an eutopsy rmed?	24b. Were autopsy findings available prior to completion of cause of death?
<u>~</u>	The law ate has pege 2	E O		- 101	Vas 200 No	1 ☐ Yes 2 ☐ No
Vital	iclan: The I certificate ha	Be	examiner?	ath (Check only o		
6	this al di	2		lome 5 ☐ Resi	dence 6 □Oth how injury occur	
0	5 T S	탏	27. Menner of Deeth 1 Naturel 5 Pending (Month, Dey Year) 28a. Date of tnjury (28b. Time of tnjury tnjury M 1 Pes 2 No			
Division	or Attending after death. Director: Aftel	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (City or To		er or Rurel Route Number,
	To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place 2 medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place 2 medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place 2 medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place 2 medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place 2 medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place 2 medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place 2 medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place 2 medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place 2 medical Examiner: On the basis of examination end/or investigation.	e, and due to the urred at the time,	cause(s) and ma date end place,	anner as stated. and due to the cause(s)
	orthin forthe	Me	29b. Signature end title of certifier 29c. License number		29d. Date signe	d (Month, Dey, Yeer)
			My thothang lily, und D25205		SApten	nber 9, 2005
	100		30. Name end address of person who completed cause of death (Item 23e) (Type, Print) W. A. C. Ley G. Simi G78 (N. Chules St.	Balt	o. and	20204
	Sta Registr	- 61	31. Dete filed (Month, Day, Year) SEP 1 3 2005 32. Refistrer's Signeture			

		Registrar 1. Decedent's Name (First, Middle, La	st)			rtificat	COL	Jeani	2	Re 2. Date of Death	3	2005	3. Time of Death
Physicia		Robert Ross Far								Month 09	Day 04	Year 2005	
/Medica		4a. Facility Name (If not institution, giv		per)		4b. City	, Town, or	Location of I	Death		_	ounty of Death	07:03 _I
		Casey House					lockv:				M	ontgom	
Funeral Director		5. Social Security Number 6. S 478-18-9121	ex 7.	Age (In yrs.	. last birthday) Yrs.	Months Months	Days	If Under 24 Hours	Min.	I. Date of Birth (Month, Day, 11-08-	Year)	9. Birth Cou	place (State or For
		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation				11 00	1921		Iowa 10d. Inside City Lir
Hygiene. Hygiene. ont. Tra Medical Examinar must be medified at	tor	DE Sussex			Lewes								1√ Yes 2□
e or 28 Lberry	Funeral Director	10e. Street and Number 23 Postal Lane				10f. Zij	p Code	19971		10	-	n of What Cou	ntry?
ms 23	nera	11. Marital Status	12. Was Deced	ent Ever in U	J.S. 13.	Was Dece	dent of Hi		n? (Spec	fy Yes or No- can, etc.)		Race - Ameri	
ol', or ite	ρχ	1 ☐ Never Married 2점 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forc 1 X Yes 2 If Yes, Give Year or Date	No 19	46 1970	n Yes, spe 1 ☐ Yes		Specify:	Puerto Hi	can, etc.)	Sp	Black, White, bec <i>ify:</i> White	
nature Beal E	ted	15. Decedent's E (Specify only highest gr	ducation		16a. Dece	dent's Usu	al Occupa	ation	f working	, 1	6b. Kind	of Business/Ir	ndustry
Department of Heatth and Mental Hygiene. Important: If item 23e or 28a-f show important: If item 27 is marked other then "naturel", or items 23e or 28a-f show any injury or other traumatic event. The Medical Expriment must be multipled at once.	Completed	Elementary/Secondary (0-12)	College (1-4	lor 5+)		<i>po Not</i> 1 al 0:		furing most o) er	HOIKING		In	tellige mmunica	ence ations
al Hyg l other vent.	Be C	17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, Middle, M	aiden Su	mame)	
Ment sarked satic e	2	Ross C. Farrell			1					Biggle			
Ith and 27 Is m r traum		19a. Informant's Name/Relationship (Patricia Farrell		r						Route Number, ce Germa			
of Hear fitem r othe		20a. Method of Disposition 1 □ Burial 2 T Cremation 3 □	Removal from St	20b.	Place of Dispo cemetery, crei	sition (Na matory or o	me of other place	9)	Da	ie 2	0c. Locat	tion - City or T	own, State
tment tant: I jury o		* 4 ☐ Donation 5 ☐ Other (Special	y)	C1	hesapea					7-2005		ltsvill	Le MD
Depa Impo any in		21. Signature of Funeral Service Lice)5B0	_ MO(0382	2. Name a Rapt 933	nd Addres p Fur Gist	s of Facility leral { Ave. S	Cre	emation er Sprin	Serv	vice 0 20910)
	al Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, resulting to anime distance cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	as a conse	Pulmon								Onset and Deat
physis the t	edical		_ d										
or use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 ☐ Feta ntattime of o	al death 3	⊒Ectopic p ⊒ Other <i>(s</i> µ					23d	. Date of deliv Month	ery Day Year
engi pe q	ρχ	Part II. Other significant conditions	contributing to dea	th but not re	sulting in the u	nderlying o	cause give	n in Part I.					he cause of death
peen si should	etec									24a. Was an			opsy findings availa
ite has	Completed			-						autopsy performe	ed?	prior to co death? 1 🗌 Yes	mpletion of cause
certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			Check only one			
his	. To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of	Injury	ER/Outpatier 28b. Time o		OA Outo	4 🗆 140151		5 Resident d. Describe how			Mospice
death. stor: Afte the fune	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Day Year)	Injury	М		.? ∕es 2 □ No					
after death Director: I in by the	ertification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of	f Injury - At h j, etc. <i>(Speci</i>	nome, farm, str ify)	eet, factor	y, office		28	f. Location (Stre City or Town,		lumber or Rura	al Route Number,
4 hour	edical C		nysician: To the b niner: On the bas	is of examin									
within 2 To the complet	Med	29b. Signature and title of pertition	and manne	statett.		29	c. License	number		290	d. Date s	igned (Manth,	Day, Year)
> F 0		XHIII				-	D41	218			09-0	5-2005	
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DHMH 17 Rev 1/2001

			1 - For State Registrar		State of	Maryla	nd / Depa <i>Cei</i>	artment rtificate			and M	ental Hy	/giene	Z 11 11:	5 2	9695
	Physici	an	Decedent's Name (First,									2. Date of Di Month	eath Da	y Ye		ime of Death
	/Medic	al	Elizabeth C. 4a. Facility Name (If not ins			harl		4h Cin. 7	Fa	1		Septem		10, 20	0.5	6 PM M
	Examin	er	Oakcrest Vil		street and nun	iber)		40. City,		Location of arkvi				County of D		
2.	Funeral	16	5. Social Security Number	6. Se		7. Age (In yrs	. last birthday)	If Under	1 Year	If Under 2	24 Hrs.	8. Date of Bi	rth			State or Foreign
	Director		095-14-4696		□ M 20F	84	Yrs.	Months	Days	Hours	Min.	07/09/			Country)	
	and		Usual Residence of Deceder 10a, State 10b, C			10c. C	ity, Town or Lo	cation							10d for	side City Limits
	Maryl febo	tor	MD Bal	timor	e		kville									Yes -≱d No
	r 28a	Director	10e. Street and Number					10f. Zip	Code				10g. Ci	tizen of What	Country?	
	th with	al D	8820 Walther	Blvd	Apt. 41	99		2123	34				Unit	ted Sta	ates	
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-f show spir injury or other traumatic event, the Medical Examinant must be notified at once.	Funeral	11. Marital Status 1 Never Married	Married	12. Was Dece Armed For 1 Yes	ces? 2N⊒No		f Yes, speci	ify Cuban	n, Mexican,	in? (Spe , Puerto I	cify Yes or N Rican, etc.)	0-	14. Race - A Black, W	hite, etc.	ian,
00	ural',	d by	3 Widowed 4 Div	orced	If Yes, Give Year or Da	tes:		1 □ Yes 2	S INO	Specify:				Specify. Wh	ite	
15 17	n 72 h "natu	Completed	15. De (Specify only	cedent's Ed highest grad	ucation de completed)		(Give	lent's Usual kind of work OO NOT use	k done di	uring most	of workir	ng		and of Busine cetaria		
12	withi	ото	Elementary/Secondary (0	-12)	College (1-	4or 5+) 1	Secret		,		Own	er	beer	Courte		
b	i Hyg other	Be C	17. Father's Name (First, M	iddle, Last)		· -				18. Mother	r's Name	(First, Middle	, Maiden	Surname)		
<u>Jar</u>	utd by	To E	Ralph Chambe	rlain						Mildr	ed E	o uve				
Maryland 21215-0036	2 sho and le mu		19a. Informant's Name/Rel	ationship (7	урө, Print)									or Town, State		
ر ق	1 and Health em 27 ther ti		David V. Fick 20a. Method of Disposition	/hu	sband	20h	Place of Dispo			IVd A		4199 P ate	_	ille,		
altimore,	ages nt of h t: If ite		1 🗆 Burial 💢 Crem			itate	cemetery, cren	natory or oth	her place	· 1	S	ep 12		ocation - City sville,		
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ä	per lmp		Junel	In (Ritter	Mary	Cr Cr	ematic	on an	d Fun	eral	Altern		es more, M	arvlan	d
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	/Medical Examiner		resulting in death)		a	or as a conse										-
	Examiner	-	Sequentially list conditions		b. ————————————————————————————————————	11 do d CUIISBO	- nen ell									
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Ć.	execuin and ial-tra	Exal	that initiated events resulting in death) Last	18	Due to (c	or as a consec	quence of):		-						-	
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	that in the property of the pr	by Ph	Part II. Other significant co	nditions co	ontributing to de	ath but not res	sulting in the ur	nderlying ca	use giver	n in Part I.		23e. Did 1	obacco u	use contribute	to the caus	e of death?
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Vital	ician: Th certificate rector, pag	Be	25. Was case referred to m examiner?	-	Lloanitof:				1 -	,		Check only				
o	Attending Physician: r death. ector: After this certifica by the funeral director, p	7	1 Yes 2 No 27. Manger of Death		Hospitaf: 1 □ In 28a. Date o		ER/Outpatien			402 Nurs				6 □Other (S	pecify)	
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N S	Atter dea octor by the	Certification:	3 Suicide 6 □ C	could not be etermined	28e. Place	of Injury - At h	ome, farm, stre					8f. Location (Street an	d Number or	Rural Route	Number,
ā	tal or A	Cert	4 [] Hollicide		buildin	g, etc. (Speci	ny)					City or To	wn, State))		
	To the Hospital or within 24 hours after to the Funerel Director completely filled in the formula of the formul	Medical	29a. Certifier (Check only one)	tifying Phy dical Exam	sician: To the liner: On the ba	sis of examina	owledge, death ation and/or inv	occurred a estigation, i	t the time in my opi	, date and nion, death	place, a	nd due to the d at the time,	cause(s) date and	and manner d place, and d	as stated. ue to the ca	use(s)
	To ti To ti Somp	ž	29b. Signature and the of c	entier					License		_		29d. Dat	te signed (Mo	nth, Day, Yo	ear)
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1	Sta Registr		31. Date filed (Month, Day, SEP	Year) 1 3 20	05 32/Ae	gistrar's Signa	atura Apo	will								

Elizabeth Ficker

			1 - For State Registrar	State of Maryland		nt of Health and I te of Death	Mental Hygier	2000	29696
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Las CLYCC C 4a. Facility, Name (If not institution, give	for	rester	Town, or Location of Death	Sept. 12	Day Year 2 2-05 4c. County of Death	3. Time of Death 220 A M
	Funeral Director	٠. جي ا	5. Social Security Number 6. Se 216-76-6410 11 Usual Residence of Decedent	Clater 7. Age (In yrs. last 6 40	1	uther ville	8. Date of Birth (Month, Day, Yea	Booth ar) 9. Birthp Coun	time Co place (State or Foreign place)
	deeth with the Maryland ms 23a or 28a-f ehow	Director	10a. State 10b. County) (A 10c. City, To	own or Location	ltenin			0d. Inside City Limits Yes 2 □ No
	deeth with	Funeral Dir	312 E 20	12. Was Decedent Ever in U.S.	A	Code 2/2/8 dent of Hispanic Origin? (Sp		Citizen of What Coun	1
	72 hours after dee "natural", or Itams alical Examener in	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1 □ Yes		Rican, etc.)	Black, White, of Specify:	
-612121	be filed within 72 hours after deeth with Hygiest deeth with Hams and other than "natural, or frams 23sevent, the Medical Exament must	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	6a. Decedent's Usu (Give kind of wo life. DO NOT u	ork done during most of work se retired)	zer t	touse/	ustry
ryland	Men Men arke	To Be	17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (7.	Forrester		18. Mother's Nam S (Street and Number or Rui	e (First, Middle, Maide	ici	0.41
re, ma	es 1 end 2 sho of Health and fitem 27 is m r other traum		Patrease S. S.	anders - 3		th St. Apt.	A. Bulto	1	1218
бант	permit. Page Department o Important: If eny injury or once.		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify) Aeritoval from State	our 2		Fred this		, , , , ,
	Physician /Medical Examiner		Immediate Jause (Final disease or condition resulting in death)	lications that caused the death. Done cause on each line. a		de of dying, such as cardiac	or respiratory arrest,	re, Bal	do, md, 21226 Approximate Interval Between Onset and Death Yuss
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O. DOX 0	ires that the death certific signed by the attending p d be detached for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown				23d. Date of deliver Month	y Day Year
cords, r	w requires that been signed b should be deta	ል	Part II. Other significant conditions co	ntributing to death but not resulting	g in the underlying c	ause given in Part I.		use contribute to the	e cause of death?
ומו חפכי	in: The law re lificate has be or, page 2 sho	e Completed	25. Was case referred to medical				24a. Was an autopsy performed?	prior to com	sy findings available ipletion of cause of
	to the nospital or Attending Physician. The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	To B	examiner? 1		Outpatient 3 DC Time of Injury M	Other: 4 Nursing Ho	n (Check only one) me 5 ☐ Residence 28d. Describe how inju	Other (Specify)	nospice
Ž	prise or Am burs after de eral Directe filled in by t	i Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)			28f. Location (Street a City or Town, Stat	'e)	
	within 24 ho	Medical	(Check only 2 Medical Examione) 29b. Signature and title of certifier	sician: To the best of my knowled ner: On the basis of examination a and manner stated.	and/or investigation	at the time, date and place, , in my opinion, death occurr :: License number	ed at the time, date an	s) and manner as stand place, and due to the signed (Month, Date in the signed (Month, Date in the signed (Month, Date in the signed (Month, Date in the signed in the sig	the cause(s)
5	3		30. Name and address of person who co	ompleted cause of death (Item 23a	(Type, Print)) 58303		otember	12 2005
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signature	larles	St Powson	, mo 21	204	
	Registra	ir	SEP 1 3 200	15 Marian It	Boarde		~		

Formster, Patricia C 9-12-05e 2 2m

State of Maryland / Department of Health and Mental Hygiene 29697 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year 12:59 AM FEINSTEIN September DAVID 10 200 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Sinci Hospital of Boltimore Boltimore City N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
JULY 4, 1912 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2□ F 014-05-6901 93 Yrs. MASS. Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits , or Items 23a or 28s-f ehow 1 ☐ Yes 2 ▼ No Funeral Directo BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6507 GLENWICK COURT 21209 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No WWII If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, Whife, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No WHITE þ Specify: 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If Item 27 ie marked other the any injury or other traumatic event. Ite 2008. 12 PROPRIETOR DRY CLEANING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **FEINSTEIN** JOSEPH FREIDA (UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6507 GLENWICK COURT - BALTIMORE, MD 21209 NANCI GROSSMAN / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHEVRA AHAVAS CHESED 109/11/2005 RANDALLSTOWN, MD 21. Signature Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atheroschrotio coronary /Medical Due to (or as a consequence of) Examiner S- uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) o. 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Dther significant conditions confributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Donknown 1 Tes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 2 No 1 Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 1 Yes 2 No After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: A death. 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide after within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10023377 September 10, 2005 M.D 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 West Belvedere Avenue, Baltimore, Maryland ALI, M.D. 1AHAJABIN 2/2/5 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2005

crn	1 - For State		State of	Marylan	•	artment of I				giene Reg. No.	2005	29698
	Registrar 1. Decedent's Na	me (First, Middle, I	.ast)			timodio or	Doui		2. Date of De			3. Time of Death
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/Medical		(If not institution, g		nher)		4b. City, Town,	or Location		Magast		County of Death	J.11 A
Examiner	3227 No	orthway D	rive			Ba	ltimo	re			N/A	
Funeral Director	5. Social Security 219-58-		Sex 11 M 2□F	7. Age (In yrs. 55	last birthday) Yrs.	If Under 1 Year Months Days		er 24 Hrs. Min.	8. Date of Bir (Month, Da 09/12	th ay, Year) 2/194	Cour	lace (State or Foreign try)
g .	Usual Residence	of Decedent		100 Cib	y, Town or Lo	nation						0d. Inside City Limits
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5 2 B 5	1 Never Ma	o arried 2□ Married I 4□Div o rced	Armed For	ces2 2 No e		Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 No			Rican, etc.)	l l	Black, White, Specify: Whit	etc.
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Baltimore, semit. Pages 1 at 29 pertinent of Hea mportant; if them my injury or other ance.	1 🗆 Burial	2 Cremation 3 n 5 Other (Spec		State	emetery, crer esapea	natory or other pla ke Crema	tory	Inc.	Sep 14 2005	Belt	sville, 1	
Balt permit. Depertimports eny inj	21. Signature of	Funeral Service Lic	Retty	- MO1		Name and Addr Cremation 1717 Greer						yland 21286-
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Divisio To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the t. Medical Certificati	29a. Certifier (Check only one)	1☐ Certifying I 2☐XMedical Ex	Physician: To the aminer: On the ba and mann	sis of examinat	wledge, deatl tion and/or in	occurred at the t vestigation, in my	me, date a	and place, a eath occurre	and due to the ed at the time,	cause(s) a date and p	nd manner as st blace, and due to	ated. the cause(s)
To the withing to the comp	29b. Signature a	title of certifier	$\bigcap \Lambda$	Λ		29c. Licen					signed (Month, I	
		TICM	N/V				.C.M.	Ε.		Augus	t 18, 20	005
2	30. Name and ac	R. HO	o completed cause	of death (Item		_{enn} Stre	et, E	Baltim	ore, Ma	aryla	nd 21201	
State Registrar	31. Date filed (M		2005 32. Re	egistrar's Signa		all .						

State of Maryland / Department of Health and Mental Hygieng O

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NELS	ON M. G	ARI	1 _ For	State of Mai	ryland / D	epartme	ent of He	ealth and M	ental Hy	giene 0	05 296	99
	_		Registrar 1. Decedent's Name (First, Middle, Last	')		Jerunca	ite of D	eatri	2. Date of De.	Reg. No.	3. Time of	Death
_	Physici /Medic		Nelson		Gardi	ner			Month	Day	Year	Λ M
	Examir		4a. Facility Name (If not institution, give	street and number)			y, Town, or L	ocation of Death	OHIT.	4c. County		A
			3903 72nd AVENUE					R HILLS		PRIN	CE GEORGES	
	Funeral		5. Social Security Number 6. Se 1.2	x 7. Age (JM 2□F	(In yrs. last birth	Month		ff Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	y, Year)	Birthplace (State or Country)	Foreign
	Director		Usual Residence of Decedent		59 ^Y		1		May 26	, 1946	Pennsylvan	ia_
	yland how		10a. State 10b. County	1	10c. City, Town	or Location					10d. Inside Cit	y Limits
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	vith th	Funeral Director	10e. Street and Number				ip Code			10g. Citizen of \	What Country?	
	a 23a	ra	3903 72nd Avenue	10 W- D1			20784			U.S.A		
10	fter de	Fun	11. Maritaf Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ev Armed Forces? 1 NYes 2 No		If Yes, sp		panic Origin? (Spe Mexican, Puerto F	city Yes or No- Rican, etc.)	- 14. Had	e - American Indian, ck, White, etc.	
98	urs a	by	3 ☐ Widowed 4 🏋 Divorced	1 XYes 2 No If Yes, Give 1 — Year or Dates to	26-68 6-5-78	1 🗌 Yes	21X No	Specity:		Specify	" White	
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21	han han	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)) !			ring most of workin	,y			
5	Hygie Hygie ther t	ပိ	12 17. Father's Name (First, Middle, Last)		5	ervice		11C1an 8. Mother's Name	/First Middle		& Decker	
ano	2 should be filed within 72 hours after death with the Manyland end Mental Hygiene. is marked other than "naturel", or Itama 23a or 28a-f ehow eumatic event, the Medical Examinational be notified at	o Be	Joseph Gardiner				1				ie)	
Ž	shoul nd Me mark	၉	19a. Informant's Name/Relationship (7)	rpe, Print)	19b. N	Maifing Addre	ss (Street and	Lydia M			State, Zin Code)	
Ž	alth e		Kim Bianchi (Dau	ghter)				., McDon			51410, 21p (3330)	
J.e.	ages 1 and 2 should but of Health end Ment t: If Item 27 is marked or other treumatice		20a. Method of Disposition		20b. Place of D				ate		City or Town, State	
Ĕ	Pages ment of t ant: If It ury or o		1 A Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)					ery 9/15	/05	McDona1	d, PA	
Baltimore, Maryland 21215-0036	permit. Page Department Important: It any injury o		21. Sign rure of Funeral Service Licens	Dittmes	70	22 Name	and Addrage					
			23a. Part1. Enter the disease, or complishock, or heart failure. List only of	ications that caused th	ne death. Do no	t enter the m	ode of dying,	such as cardiac or	respiratory ar	rest,	Approximate Interval Betw	
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ds, P	signed b	þ	Part II. Other significant conditions con	ntributing to death but r	not resulting in the	he underlying	cause given	in Part I.			ibute to the cause of dea	
Divislon of Vital Records, P.O	s law requir hes been si e 2 should l	Completed							24a. Was a	an 24b. V	Vere autopsy findings av	
<u></u>	W CT								perfor 125 Yes	mea? a	eath? C√es 2□ No	
V.	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner? 1 X Yes 2 No	lospital:			1 04	6. Place of Death				
of	a Phy er this eral d	٠. آ	27. Manner of Death	28a. Date of Injury (Month, Day Y	2 ☐ ER/Outp		28c. Injury at Work?			ence 6 XOthe	or (Specify) AT SC	ENE
<u>o</u>	ndlng ath. r: Afte e fun	Certification:	1 Naturaf 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	<i>'ear)</i> Infi	ıry M		s 2 No		,,		
vis	Atts er de racto by th	<u>=</u>	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm	, street, facto	ry, office	28	Bf. Location (S	treet and Numbe	er or Rural Route Numbe	9 <i>1</i> .
Ö	rs effe	Cer		building, etc. (эрвспу)				City or Town	n, State)		
	To the Hospital or Attanding Physician: within 24 hours effer death. To the Funeral Diractor: Affer this certific completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying Physical Check only one) Medical Examination	sician: To the best of ner: On the basis of ex and manner stated	camination and/o	death occurre or investigation	d at the time, n, in my opini	date and place, ar ion, death occurred	nd due to the c d at the time, d	ause(s) and mai ate and place, a	nner as stated. nd due to the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier			29	O.C.			9d. Date signed SEPT. 1	(Month, Day, Year) 1, 2005	
-	5		30. Name and address of person who co	mpleted cause of deat	th (Item 23a) (Ty	(pe, Print)	ਹਿਰਾ ਹ	AT ("TX#\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	MADST	NTD 0100	,	
	Sta	te	31. Date filed (Month, Day, Year) SEP 1 3 20	32. Registrar's	Signature	POSTE	eel, B	MULLINOKE	, MAKYLA	ND 2120.	L	
	Registr	ar	SEP 1 3 20	U3 Delica	D 16 1							

			1 - For State Registrar	State of M	laryland	-			ealth and I Death		Reg. No. 200	
п	Physici		Decedent's Name (First, Middle, the Elaine Helen						9	2. Date of De Month EFTEMB	Day Year	3. Time of Death 12: 2121A M
	/Medi Examir		4a. Facility Name (If not institution, g Saint Joseph			r	4b. City	, Town, or	Location of Death		4c. County of De Balt	ath :imore
	Funeral Director				ge (In yrs. las		If Unde Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da		rthptace (State or Foreign country)
	Maryland f ehow	lor	Usual Residence of Decedent 10a. State 10b. County MD Balt	more		Town or Lo						10d. Inside City Limits
	h with the	al Director	10e. Street and Number 8429 Pleasant P	lains Rd.	.1		10f. Z	ip Code	1286		10g. Citizen of What C	country?
920	within 72 hours after death with the Maryland one. than 'naturel', or Items 23a or 28a-f ehow the Maryland Experiment to modified at	by Funeral	11. Marital Status 1 Never Married 24 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	? No	1	Was Dece f Yes, spo	ecify Cuba	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	1	
21215-0036	in 72 hours aff n "naturel", or	Completed by	15. Decedent's (Specify only highest (grade completed)		16a. Deced (Give life. L	kind of w	ual Occupa ork done o use retired	turing most of wor	king	16b. Kind of Busines	s/Industry
	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Manatic event, the Manatic event, the Manatic event, the Manatic event.		Elementary/Secondary (0-12) 12	College (1-4or	·	Home	nake	r	19 Mathara Nama	no (Eirot Middle	Own	Home
Maryland	ild be fillental H ked otl	To Be	17. Father's Name (First, Middle, La Harry R. Hild	St)						Almony		
Mary	ges 1 and 2 should b t of Health and Ment if item 27 ie marked or other traumatic e		19a. Informant's Name/Relationship				_		and Number or Ru	ral Route Numbe	er, City or Town, State,	
	s 1 and 2 of Health Item 27 I		Oney H. Green/1 20a. Method of Disposition	nusband	20b. Plac	ce of Dispo	sition (Na	ame of		Rd. To	OWSON, MD 20c. Location - City of	
Baltimore,	Pages ment of h ant: If its ury or of		Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Removal from State city)	9	netery, cren	-		0	1 K ardens	Timonium	MD
Balt	permit. Pages Department of Important: If I eny Injury or once.		21. Signature of Funcian Service Co	onsee		22	. Name a Lemi	and Address	s of Facility Funeral	Home of	Dulaney \	/alley, Inc.
			23a. Part 1. Enter the disease, or co shock, or heart failure. List or	.emmon implications that cause by one cause on each	ed the death.	Do not ent	er the mo	Pade ode of dyin	onia Rd. g, such as cardiad	, Timon or respiratory a	nium, MD 2 rrest,	1093 Approximate Interval Between
8	Physician		Immediate Cause (Final disease or condition resulting in death)	a CARDIO		THY						Onset and Death
	/Medical Examiner			Due to (or as	s a conseque RY AR		DIS	SEASI	divinos permitares			
	D #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D	s a conseque							
,09	be executed sicien and burial-transit	ai Examine	Cause (Disease of Injury that initiated events resulting in death) Last		s a conseque	nce of):						
687	ntificate ng phys as the	Aedic	IF FEMALE:	d								
.O. Box	The law requires that the death certificate to the has been signed by the attending physic page 2 should be detached for use as the b	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal de	eath 3	Ectopic Other (s	pregnancy specify)			23d. Date of d Month	elivery Day Year
a	iw requires that the s been signed by the should be detach	ьу Р	Part II. Other significant condition	s contributing to death	but not resulti	ing in the u	nderlying	cause give	en in Part I.		tobacco use contribute	
Records,	require	eted	ACUTE RENAL FAIL			·					Yes 2 No 3 F	
al Rec	(0	Completed	DIABETES MELLITU	S TYPE II						24a. Was autor perfo 1 \(\text{Yes}	psy prior to ormed? death?	autopsy findings available completion of cause of
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ion of	Jing F After fune	ation: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Inj (Month, D	iury 2: ay Year)	8b. Time of Injury	М	28c. Injury Work	yat ⟨? Yes 2 □ No		how intury occurred	
Division	Dir	Medical Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	286. Place of it	niury - At hom etc. (Specify)	e, farm, str	eet, facto	rry, office		28f. Location (: City or Tox	Street and Number or F wn, State)	Rural Route Number,
	Hospital 24 hours a Funeral	dical (29a. Certifier 12 Certifying (Check only one) 2 Medical Ex	Physician: To the bes aminer: On the basis and manner s	of examinatio	edge, death n and/or in	occurre vestigatio	d at the tin	ne, date and place pinion, death occu	, and due to the irred at the time,	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
	within To th	Me	29b. Signature and title of certifier				2	9c. License	number		29d. Date signed (Mor	_
, ,	0//		20 Name and	Formal and	doub /l	(39) (7)		D 37	254		4/0/0	5
1			30. Name and adoress of person w	D 76/01	ASI FE	DRT	VF.	TOWS	ON MARY	LAND 2	1204	
100	St Regist	ate rar	31. Date filed (Month, Day Pres)	3 2005 ^{2. Regis}	trar's Signatur	re de	400	es o				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygienes For State Registrar 29701 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician 10:40 a M William Joseph Greenwich September 8, 2005 /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Mariner Health Care Glen Bullite

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplece (Strongth) | 1913 | Maryland Glen Burnie Anne Arundel Birthplece (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1/2M 2/1F 215-03-0024 92 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 27s - ----- any injury or other traumath. 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 USA Funeral 2814 Manoff Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WW II 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 TNo Specify δ WW II 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Taylor Clothing Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Grinevicius Galiniute 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Schweitzer (Daughter) 2814 Manoff Road, Baltimore, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery 19/14/05 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition CARCINOMA Physician resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner use as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetel death 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 ☐ Other (specify) 1 Yes 2 No 9□ Unknown 9 Unknown cate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ ANGMIA 3 Probably 4 Onknown Completed PERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan autopsy performed? Yes 2.25No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 1 (2Natural 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 1 [P Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier my wo. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1. ALLAN MACTONA, MD. 710 CHURCH 51. BALTIMORE 621 31. Date filed (Month, Day, Year) SEP 1 3 2005 32 Registrar's Signature State Registrar

or Print in Black Indelible Ink. Ensure All Copies Are Legible. 005 29702 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician Month O 1442 2005 /Medical Facility Name (If not institution, give street and number 4b. City 4c. County of Death Town, or Location of Death Examiner vrs. last birthday) Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months 98 Days Min 1 □ M 2 F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Exercities for items 20s. On the 120s. 10a. State 10d. Inside City Limits 1 Yes 2 □ No Director 1timore 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 403 To Be Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ☐ Yes 2 No Yes Give Baltimore, Maryland 21215-0036 1 Yes 2000 Specify: (3) Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) dary (0-12) 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame) 18. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) the of Disposition

Burial HOMD 21239 pug 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State ^ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MANTESTIN **Physician** OBST RUCTION disease or condition resulting in death) WEEKS /Medical Due to (or as a consequence of): Examiner COLUN CANICEX Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine use as the burial-transit To the Hospital or Attanding Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate 2ET No 2 1 No 1 Yes Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: ျှ Other: 2 No 1 ☐ Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) To the Funeral Director: After th completely filled in by the funeral 27 Manner Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after 1 (F Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2047945 12 Zue 5 uns 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 JUS OSCER DRIVE TOWSON IND HARIS ALGEM 31. Date filed (Month Day 💋. Registrar's Signature State 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 05 29703

			1 - State Registrar			Ċe	rtifica	te c	of Death		Reg. N	6.		100
	a to b	¥	1. Decedent's Name (First, Middle, Last)							2. Date of D		ay Year	3. Time o	f Death
	Physicia /Medic			Barron	T.	Grace				Septer	nber	8, 2005	4:55	РМ
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City	, Tow	n, or Location of Death		4	c. County of Death		
		& .	Suburban Hospital						esda	,		Montgome	-	
i de	Funeral Director		417-76-0505	7. Ag	6 (In yrs. 52	. iast birthday) Yrs.	If Unde Months			8. Date of B (Month, L March	irth Day, Yea 14,	9. Birthy Cou 1953 New	York	or Foreign
-	pu >		Usual Residence of Decedent 10a. State 10b. County		10c Ci	ity, Town or L	ocation						I Od. Inside C	City Limits
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	ith the Marylar or 28e-f show	Director	Maryland Montgome	гу		Dethes	10f. Z	in Cor	10		10g. (Citizen of What Cou		
		rai Dir	7501 Democracy Blv					2	0817		Un	ited State	es	
	ler deeth w Items 23e	Funeral	Tr. Maria Batas	12. Was Decedent Armed Forces?		J.S. 13.	Was Deci	edent ecify (of Hispanic Origin? (Sp Cuban, Mexican, Puerto	Rican, etc.)	10-	14. Race - Americ Black, White,		
Marvland 21215-0036	urs after	þ	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X If Yes, Give Year or Dates:	NO		1 🗆 Yes	2 X	No Specify:			Specify: Wh:	ite	
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121	within ene. then	mp	Elementary/Secondary (0-12)	College (1-4or	5+)	1			ontrol Anal	lvst		IBM		
2	Hygie ther int,		17. Father's Name (First, Middle, Last)	7		(=====			18. Mother's Nam	-	le, Maid	en Sumame)		
an	d be ental	o Be	Clinton H. Grace						Grace V	Wright				
2	shoul nd Me mari	ဥ	19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Mail	ing Addres	s (Str	reet and Number or Ru	-	ber, City	y or Town, State, Zip	Code)	
	nd 2 alth a 27 lo		Grace Grace/ Mother 7501 Democracy Blvd., Bethesda, Maryl									Maryland	20817	
Baltimore	parmit. Pages 1 and 2 should be filed Deperment of Health and Mental High Importent: If Item 27 le marked other eny injury or other traumatic event, and page.		20a. Method of Disposition 1 🛣 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)			Place of Disponentery, cre			Sept	Date ember 2005	Si	Location - City or To x Mile Rui nnsylvania	n,	
Balti	permit. 8 Depertm Importer eny Inju		21. Signature of Funera Price Lions			RC RC	2. Name a	and Ac	dress of Facility Pumphrey Fune ontgomery Aver	ral Home	/Roc	kville. Inc		-2805
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that cause	d the dea							e, marymak	Approxima Interval Be	ite
	Physician		Immediate Cause (Final disease or condition			n/ C	2001	10	MA DE A	SADIT	KA-BI	25	S Mo	Death
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大丁の	that the digital the dot the detached	isk	1 Yes 2 No 9 Unknown	9□ Unknown										
56	s that ned b	by Pi	Part II. Other significant conditions co	ntributing to death t	out not re	sulting in the	underlying	cause	e given in Part I.	23e. Did	tobacc	o use contribute to t	he cause of	death?
20	w requires to been signs should be	d b	HYPERCALCEM	114						1 [] Yes	2 No 3 Pro	oably 4X]Unknown
Record	aw re	Completed								24a. W		24b. Were auto	opsy findings	available
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Sit S	ician: Th certificate rector, pag	0	25. Was case referred to medical						26. Place of Dea					
7 5	ysicia is ceri	To B	examiner?	lospital: 1 4mpati	ent 2	∃ER/Outpatie	ent 3∐ [AOC	Other: 4 Nursing H	ome 5 Re	sidence	6 ☐Other (Speci	(y)	
Barron a of Vital	ding Phy.		27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Inju	ury ay Year)	28b. Time Injury	of	28c.	Injury at Work?	28d. Describ	e how in	jury occurred		
	ttendin death. ctor: At	atic	2 Accident investigation				М		1 ☐ Yes 2 ☐ No					
Srace, B		Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In building, e	jury - At i tc. (Spec	home, farm, s	treet, facto	ory, off	fice	28f. Location City or 7	(Street own, St	and Number or Run ate)	al Route Nu	mber,
Gr	Hospitel 24 hours a Funerel I	Medical C	29a. Certifier 1 Cartifying Phy (Check only one) 2 Madical Exam	sician: To the best iner: On the basis of and manner s	of examin	nowledge, dea nation and/or i	th occurre	d at thon, in r	ne time, date and place my opinion, death occu	, and due to the	e, date a	o(s) and manner as s and place, and due t	stated. o the cause	(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier				2	9c. Li	cense number		29d. l	Date signed (Month,	Day, Year)	
		1	With Pmyo	m				De	23308		SI	FPT. 10,2	005	
	10		30. Name and address of person who c	ompleted cause of	death (Ite	em 23a) (Type	, Print)							
_	U-		VICTOR M. PRIEGO, 1		ORO	CKLEDO	E DI	2.	#4100 B	CTIVES	DAI	MD. 208.	17	
	Sta	ate	31. Date filed (Mon Span) Year) 3 2	105 32. egist	rar's Sign	natule	2000	1						

State of Maryland / Department of Health and Mental Hygiene 2005 29704 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** September 9, 2005 6:40 Greear (nmn) /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Harford Lorien Nursing and Rehabilitation Cen. Belcamp 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2000 Director 25,1917 | North Carolina 219-01-3646 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County ?7 is marked other than "netural", or Items 23a or 28e-f show treumatic event, tra Modical Examiner must be notified at 1 Yes 2 No Director Maryland Harford Belcamp 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1123 Belcamp Road 21017 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 21215-0036 1 ☐ Yes 2 No Specify Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Restaurant 8 Cook 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be and Mental I þe Richardson Maude Absher Calvin Nancy John ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 Is any injury or other tree once. Barbara S. Owen-Daughter 1905 Philadelphia Road, Joppa, Maryland 21085 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1√2 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Bel Air Mem. Gardens 9/12/05 Bel Air, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. Mark 1 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List say are cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit 68760 ding physician Physician/Medical use as the IF FEMALE: . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for P.O. I 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 🗌 Yes 2 Xno 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has I irector, page 2 s autopsy performed? res 2.27No 1 ☐ Yes 2 No 1 ☐ Yes Hospitel or Attending Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 12 Nursing Home 5 - Residence 6 - Other (Specify) P 2 No 1 Yes this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After 5 Pending investigation 1 Natural death. 1 TYes 2 No 2 Accident within 24 hours after death

To the Funerel Director:
completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 (20certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 (2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marchant Ad cure W 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 2005 29705 1 - For State Ragistrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Clara E. Heim рм September 9 2005 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Presbyterian Retirement Home Towson Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) July 3, 1 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 215-01-7555 95 Director 1910 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f shot treumatic event, the Madical Examinar must be notified at Maryland Baltimore 1 ☐ Yes 2√ No Towson Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 400 Georgia Court 21204 United States death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) Coltege (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ages 1 and 2 should be fill nt of Health and Mental H I: If item 27 is marked off Henry Ruppel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph C. Heim, Jr. / Son 9541 Longview Drive, Ellicott City, Maryland 21042 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Importent: If i any Injury or o 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 9/13/05 Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature il Funeral Service Mcensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prenmonia Physician one week /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit executed Dua to (or as a consequence of): of Vital Records, P.O. Box 68760, attending physician for use as the buria 9 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? A12Leinis () o mention 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2 X No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred ol or Attending F after death. 1 Natural
2 Accident 5 Pending investigation filled in by the fo 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitel within 24 hours a To the Funerel I Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Attending mo GAOI N. Cherles St., Sate 4105, Bakhum, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Green, Kenuth 00 31. Date filed (Month, Day, Year) SEP 1 3 2005 2. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2005

				C	Certificate of	Death	Re	g. No.	29/06		
Physic	rian	1. Decedent's Name (First, Middle, Las	3-11				2. Dete of Death	Bay 700 Year	3. Time of Death		
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) Exam	iner	4e Fecility Neme (If not institution, give	at 1 -	61.	40	4b. City, Town, or L	ocation of Death	4c. County of De			
			VUNSING	//-		If Under 24 Hrs.	793/7				
Funera Directo		229-44-9230	ex DM 2□F 7. Age (In 68	yrs. last birtho	Months Davs		8. Date of Birth (Month, Day, June 4,	^{Year)} 1937 Wa	nthplace (State or Foreign Sountry) shington, DC		
pue *		Usuel Residence of Decedent 10a. State 10b. County	100	c. City, Town o	r Location				10d. Inside City Limits		
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the the the the the the the the the the	rect	Virginia Snenando 10e. Street end Number	Jan D	· · · · · · · · · · · · · · · · · · ·	10g. Citizen of What Country?						
With with	ō	23 Valley View Roa	ad	10f. Zip Code 10g. Citizen of What Country? U.S.A.							
ms 2	Funeral Director	11. Marital Status	12. Was Decedent Ever	in U,S.	13. Was Decedent of If Yes, specify Cub			14. Race - Am			
affer o		1 ☐ Never Married 2 ☒ Married	Armed Forces? 1 ☐ Yes 2 🔀 No		If Yes, specify Cub 1 ☐ Yes 2 No		Hican, etc.)	Black, Wh			
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11215-0020 within 72 hours after death with the Marylend ene. then "naturel; or items 23a or 28e-f show its Medical Examinar must be notified at	Be Completed	15. Decedent's Ed (Specify only highest grades)	ucation de completed)	16a. D	ecedent's Usual Occu Give kind of work done fe. DO NOT use retire	pation during most of work	kina 1	6b. Kind of Busines	s/Industry		
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aryla should and Men market	Ţ	-		40h h	lailing Address (Stree			City or Town State	Zin Code)		
Man d 2 sl th an 7 to r		19a. Informant's Name/Relationship (7) Patricia Shaw Ha.	• • • • • • • • • • • • • • • • • • • •		Valley Vie				Zip Code)		
e, No. 1 and Health Health em 27 wither tr		20a. Method of Disposition		Ob. Place of D	isposition (Name of		and the figure	0c. Location - City o	r Town, State		
Peges Peges Tent of t int: If the		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State		crematory or other pla n Memorial		9/9/05 н	arriconhu	ra VA		
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Balt permit. Depertrimports any inju		1 /2 /2	1.01		Kyger Fu	neral Hom			20001		
		23a Peril Enter the disease or common	Mications that caused the	death Donot				burg, VA	22801 Approximate		
Dhamining		23a. Pert1. Enter the disease, or comp shock, or heart failure. List only	one cause on each line.	dodin. Do not	and thousand	ing, out at said a	or respiratory arres		Interval Between Onset and Death		
Physician /Medical	_	Immediate Cause (Final	Music	-1	1 3 +	Ca, ti	20		1500		
Examine		disease or condition resulting in death)	a. Myoc Due b. COVON	10/05/00 0 000	7 / 1/ 1	9, 110			13719		
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• 0 0 0	by Physician/	Part II. Other significant conditions co	-/	resulting in th	e underlying cause gi	iven in Part I.	23b. Did tob		e to the cause of death?		
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d be	d b						24a. Was an	autopsv 24b	Were autopsy findings		
cord v require been signature	ete						perform		available prior to completion of cause of death?		
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	Be Completed	25. Was case referred to medical				26 Place of Deat	th (Check only one	/	1 ☐ Yes 2 ☐ No		
VISION Of VITA Attending Physician. or death. ector: After this certific by the funeral director.	ToB	examiner?	Hospital: 1 ☐ Inpatient	2 □ FR/Outpa	atient 3 DOA Ot	A STATE OF THE PARTY OF THE PAR		nce 6 □Other (Sp	ecify)		
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OIVISIO or Attendati after deati Director: Jin by the	E	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (St	At home, farm	, street, factory, office		28f. Location (Stre City or Town,	eet and Number or F	Rural Route Number,		
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DIVISION OF To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edicai		reician: To the best of my iner: On the basis of exar and manner steted.								
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- 1	5	30. Name end address of person who d	completed cause of deeth	(Item 23a) (Ty	pe, Print)	1 - 1		- J			
	0	Gary KazlowM	10805	Hick	ory Rid	seRd	Colum	nsia, M	121044		
St	ate	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature	_	,					
Regis	trar	SEP 1 3	2005 Maria	as St	parte						
DHMH 16 Day 6	n.c		-		0						

State of Maryland / Department of Health and Mental Hygien 2005 1 - For State Registrar 29707 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) sept. ^{ay}2005 **Physician** Blane 8:55am Ray /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Genesis Heritage Nursing Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours Min. 1**⊠** M 2□ F 55 219-50-0936 Director March25,1950 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event. The Medical Examinar must be notilized at 1 ☐ Yes 2 🛣 No MD Baltimore Dundalk Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 7301-A Dunwall Court 21222 USA death Funerai 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Herbert Hock Helen P. Funk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward T. Gould 12112 Buttonwood Lane Baltimore MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages nent of F permit. Pages Department of I Important: If it any injury or or once. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Bayview Crematory 9/12/05 Baltimore MD ^ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee ConnellyFuneralHomeofEssex on 300 Mace Ave. Baltimore MD 21221 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List on one cause on each line. Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner certificate be executed use as the burial-transit that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No detached 9 Unknown s been signed by the should be detache 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 212 No 1 🗌 Yes Division of Vital or Attending Physician: funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Νo 4 V Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainer as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) son who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2005 29708

				Certificat	e or L	Jeath		R	leg. No.		2310
Physician /Medical	HUNKY		SEPTEMBEI			BER 10	Year 2005	3. Time of Death			
Examiner	Lorien Bel	Air				Bel /				PORL	
Funeral Director		6. Sex 7. Ag	e (In yrs. last birth 33 Y	Months	1 Year Days	If Under 2 Hours	Min. 8. C	pate of Birth	0 ^{Year} 1922	9. Birthplac	e (State or Foreign
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within 72 hours after deeth with the Marylend ene. ene. than "natural", or items 23a or 28e-f show the Madeal Examiner must be notified at hompleted by Funeral Director.	11. Maritaf Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 1 If Yes, Give Yeer or Dates:		13. Was Deced If Yes, spec		spanic Orig n, Mexican, Specify:	in? (Specify ` , Puerto Ricar	Yes or No- n, etc.)		e - American ck, White, etc	
permit. Peges I and 2 should be filed within 72 hours after deeth with the Maryler Department of Health and Manual Hygiens. Department of Health and Manual Hygiens in Prince 13 or 28a or 28a-1 show my injury or other traumatic event, the Modical Examiner must be notified at once. To Be Completed by Funeral Director	15. Decedent (Specify only highes: Elementary/Secondary (0-12)	s Education grede completed) College (1-4or 5		ecedent's Usua Give kind of wo. ife. DO NOT us Cing Ma	rk done d se retired)	uring most	of working		16b. Kind of Bi		
Mantel Hy mrked othe atic event,	17. Father's Name (First, Middle, L	•							Maiden Suman uppel	10)	
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pemit. Peges 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra once.	20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donetion 5 □ Other (Sp	ecify)	20b. Place of Discomptery,	ood Cem	etery	/	9-1:	3-05	Parkvi		
Departit Departit Import any in	21. Signature of Funeral Service L	icensee		Ruck 1050	d Addres TOWS York	of Facility on Fur Rd.	neral I Towson	Home, Md.	Inc. 21204		
Physician /Medical Examiner Examiner Examiner	fmmediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	b	Due to (or as a co	nsequence of):	SE						
certificate banding physicianse as the bur	Ceuse (Disease or injury that initieted events resulting in death) Last	If any, leading to immediate cause. Enter Undertying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of): d									
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ician: Tha lew certificate has I ractor, pege 2 to Be Compi		1				26. Place	of Death (Che	1 ⊒ Ye	-	1 🗆 Y	es 2 No
Physician: this certificated director, I: To Be C		Hospitel: 1 ☐ Inpatier	nt 2□ER/Outpa	atient 3 DO	Othe			1.411.315	nce 6 □Othe	er (Specify)	
il or Attending Physician: Tha lew requiras the after death. I Director: After this certificata has been signed in by the funeral director, page 2 should be completed by certification: To Be Completed by	27. Menner of Deeth 1 Menner of Deeth 2 Accident 5 Pending investigation		Year) 28b. Tim 1nju	e of 2	Bc. Injury Work 1 ☐ Y	at ? es 2 □ N		escribe ho	w injury occurr	ed	
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To the common Name	29b. Signature and title of pertifier 29c. License number 29d. Date signed 29d. D										
611 -	39. Name and address of person w	ayfus M	ath (Item 23a) (Tv	pe, Print)	045	344	/		09/10/	2005	
State Registrar		JANA MO 32. Registre	6228	UNION	AVE	HAV	RE DE	GRACI	E,MD	21078	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Cadeat's Name (First, Middle, Last) 2. Date of Death Dav Month Year **Physician** 2:20 PM 09 09 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAMARITAN BALTIMORE 400 D HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□M 2**K**F Director with the Maryland 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location rthen "natural", or Iteme 23a or 28a-f ehow the Medical Examiner roust be notified at 1 Yes 2 No by Funeral Director 10e. Street and Number 10g. Citizen of What Country? 2 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Peges 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: if item 27 is marked other then ' ak (0-12) College (1-4or 5+) or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19a. Informant's Name Lationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Baltimore, 20a. Method of Disposition

Burial 2 Cremation 20c. Location 3 Pemoval from State Department of important: if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee un W. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. uch as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS with ACUTE RENAL FATLURE /Medical Due to (or as a consequence of): Examiner AIDS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit MIV e ctro v Due to (or as a consequence of) Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant signed by the attend to us 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ ₩6 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital : After this certifica e funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Tyes 2 **□**₩6 1 Impatient 2 ER/Outpatient 3∏ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director; completely filled in by the fi 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Penifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and Jitle of certifier 29c. License number 29d. Date signed (Month, Day, Year) ersam M. D 9 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAIDEER HINGORANI BALTIMORE 5601 LOCH RAVEN BLVD; 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 3 2005

			1 - For State of Maryland / De Registrar	partment of Health and Mertificate of Death	ental Hygien	
	·	176	Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia /Medic	40	Cecil Malcolm Heimsath		September	7 2005 9:15 P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	4c. County of Death
			Baltimore Washington Medical Center			Anne Arundel
	Funeral		5. Social Security Number 6. Sex 1×10^{-3} 6. Sex 1×10^{-3} 7. Age (In yrs. last birthday 1 of 1 of 1 of 1 of 1 of 1 of 1 of 1 o	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea March 27	9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		March 27,	,1923 KI
	yland		10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	e Ma	ctor	MD Anne Arundel Linthi	cum		1 ☐ Yes 2 ☐ No
	or 28	Dire	10e. Street and Number	10f. Zip Code		Citizen of What Country?
	ath w	rai	440 Kingwood Road	21090		J.S.A.
36	2 should be tiled within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or iteme 23a or 28a-f ehow raumatic event, it a Medical Examination to collined at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 X No Specify: 	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Ş	2 hou	ted	15. Decedent's Education 16a. De	. Kind of Business/Industry		
212	hin 7.	Completed	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4or 5+)			
2	ed wil	Co		. Navy		American Embassy
2	be fill d off	Be	17. Father's Name (First, Middle, Last) Elmer Heimsath	18. Mother's Name Bertha	(First, Middle, Maide Cohmidt	an Sumame)
3	d Mer narke	2		ailing Address (Street and Number or Rura		u or Tours Chair Tin Code)
Z	d 2 sl th an th an traur			Dogwood Road, Lint		
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Baltimore, Maryland 21215-0036	permit. Pages : Department of H Important: If ite eny injury or ot		21. Signal re of funeral service Livery see	22. Name and Address of Facility Six 1 Second Avenue S.1	ngleton Fu W., Glen F	neral Home P.A.
e destr	. *		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.			Approximate Interval Between
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€	Examiner		Sequentially list conditions. b. ORGANYC	BRAIN SYN	1) Koure	
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ita	cian: ertific actor,	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)	
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)	To th within To th compl	Me	29b. Signature and title of Certifie	29c. License number		Date signed (Month, Day, Year)
	h		30. Name and address of person who completed cause of death (Item 23a) (Ty			
_	4			pe, Print) Cofurced 57. B	ALTIMOR	=,MD21225 .
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Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	u ac	25 2 3		Vaughn (_ 4	51	51 BALTO.	NATU PIKE	, BALTO.	MO 21229		
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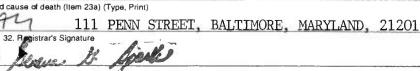
29c. License number OCME

SEPTEMBER 11, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2AB/UUNH AU 111 PENN S

31. Date filed (Month, Day, Year)



Registrar

State of Maryland / Department of Health and Mental Hygienes Reg. No. 2005 29712 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** PEGGY NOENHOU E. september 10 2005 11:56 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AGNES HOSPITAL Baltimore NA mn - 21224 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex Funeral 1 □ M 2 1 F 215.52.4806 56 MD Director Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 XYes 2 □ No BALTIMORE Director NA MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ö ROSEDALE STREET 21216 permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene Important: if Item 27 is marked other than "natural", or Items 23a any injury or other traumatic event, Ita Mudical Exercises 2006s. 1404 M. USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ■ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **MEACHER** EDUCATION YRS. 121H GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JAVANICE MOSLEY RUBY CARTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1619 POPLAR GROVE ST., BALTO. MD RUBY HAMLIN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State BALTO, MD 4 □ Donation 5 □ Other (Specify) 09.16.05 WOODLAWN 21. Signature of Funeral Service License VAUGUN C. GREENE FUNERAL SERVICE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5151 BALTO, NATU PIKE, BALTO, MO 21229 Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner use as the burial-transit The law requires that the death certificate be executed Severe attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Day Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performed kension 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Depatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Tyes 21 No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) To the Funeral Director: Attar th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 0 within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death accurred at the fine, date and place and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Medical -18613 resident MSain, M.D. September 10, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVE. MUHANMA M. 32. Registrar's Signature 31. Date filed (Month, Day, Year) 1 3 2005 State Registrar

Johnson,

			1 - For State Registrar	State of Maryla	nd / Departm	ent of Health ar	nd Mental Hy	£ 0 0 .	5 29713
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	Physici /Medi		Junes W J	chrison			SEP	Day Year	1006
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1000	- Funeral		5. Social Security Number 6. Sec	_		der 1 Year If Under 24	4 Hrs. 8. Date of Bi	N/A irth 9. Bi	rthplace (State or Foreign country)
	Director		217-66-3170 12 Usual Residence of Decedent	M 2□ F \	Yrs. Mont	ns Days Hours	Min. (Month, D	9. Bi	mi)
	how	_	10a. State 10b. County	10c. C	ity, Town or Location				10d. Inside City Limits
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 te marked other then "natural", or itema 23s or 28s-f show other traumatic event, the Madical Examenationals be notified at	by Funeral Director	10e. Street and Number	undel C	11en Bu	rnic Zip Code		10g. Citizen of What C	1 ☐ Yes 2 ☑ No
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	ema error	ıner	11. Marital Status	2. Was Decedent Ever in L Armed Forces?	J.S. 13. Was De	cedent of Hispanic Origin pecify Cuban, Mexican,	n? (Specify Yes or No	o- 14. Race - Am Black, Wh	erican fndian,
36	s afte	y Fu	1 → Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ NO If Yes, Give		2 No Specify:		Specify:	21 1
21215-0036	2 hours		15. Decedent's Edu	Year or Dates:	16a. Decedent's U	sual Occupation		16b. Kind of Business	C/Industry
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nd	tal Hy	Be	17. Father's Name (First, Middle, Last)			18. Mother's	Name (First, Middle	a, Maiden Sumame)	
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Baltimore,	permil. Pages 1 ar Department of Hea Important: If item eny injury or othe once.		21. Signature of Funeral Service License			d Address of Facility	119-121-9		SŤ
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			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the dear e cause on each line.	th. Do not enter the h	ode of ying, such as ca	rdiac or respiratory a	irrest,	Approximate Interval Between
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Vit	Phyaician: Th this cartificate ral director, pag	Be	25. Was case referred to medical examiner?	ospitaf:	3	1.	Death Check only	one	
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ion	Attending In death.	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No		mow injury occurred	
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Ö	Hospital or A 14 hours after Funeral Dire tely filled in b			7			City or Toi	•	
	To the Hospital or within 24 hours after To the Funeral Director completely filled in b	ledical	(Check only 2 Medical Examin	cian: To the best of my kno er: On the basis of examina and manner stated.	ition and/or investigati	on, in my opinion, death	occurred at the time,	cause(s) and manner as date and place, and due	s stated. to the cause(s)
	To Con	Σ	29b. Signature and title of certifier	10		9c. License number		29d. Date signed (Mont	
,	9	-	1000/	(D)		P18548		SEP 10	2005
0	2 1		30. Name and address of person who con Richard Er	icson	n 23a) (Type, Print) 22 So	oth Green	Street	SEP 11	1D 21201
N.	Sta Registr		31. Date filed (Wanth Day, Year) SEP 1 3 2005	32. Registrar's Signa	ature diameter		/		

State of Maryland / Department of Health and Mental Hygiene 2005 1 - For State Registrer Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** HARRY JAMES : 40AM 07 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner NA Good Samaritan Hospital Baltimore 7. Age (In yrs. last birthday) F Δ Yrs. Months Days Hours Min. (Month, Day, Year) 9-1-51 Birthplace (State or Foreign Country) 6. Sex **X**☐ M 2☐ F 5. Social Security Number **Funeral** 214-56-6028 Md. Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 28a-f show the Medical Examiner must be potified at 1 Yes 2X No Directo Md. Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö USA 238 2969 Yorkway 21222 death 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ent: If Item 27 is marked other than "natural", or Ite 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes X ☐ No Specify: Specify: Black 3 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Varies Laborer 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Samuel James Irene Adams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 614 S. Marlyn Ave., Baltimore, Md. f Disposition (Name of Date 20c. Location City or Town 21221 Sister Silver Patricia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Y☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 5 permit. Page Department o Importent: if any injury or once. 9-13-05 Baltimore, Md. Oaklawn Cem. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Baltimore, Md. 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition

a. SSISTS Waner 1101 E. North Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Records, P.O. Box 68760 attending physician Physician/Medical the use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy the atte Year Month 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death' Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of eause of death?

1 ☐ Yes 2☐ No page 2 s 1 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{Specify} \) 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 28a. Date of Injury (Month, Day Year) the funeral 27. Many r of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation М 2 C Accident after death 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier het Place. Dundalh person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year State 3 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 2005 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Sarah Johnson 9 2005 4:25a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore N/A 3023 E. Federal Street If Under 1 Year | If Under 24 Hrs. 8. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕏 F 216-16-9538 Yrs. Director 9-19-16 ۷a. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 77 is marked other than "neturel", or items 23a or 28e-f show traumetic event, it e Madical Examiner must be notified at 1 Yes 2 □ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to nent of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "neturel", or Items 23s or? 3023 E. Federal Street 21213 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: 3√2 Widowed 4 □ Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9th grade <u>Homemaker</u> Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert Baker Elizabeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Zelda Reid Daughter 3023 E. Federal Street, Baltimore, Md. 21213 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) permit. Page Department of Importent: if any injury or once. Garrison Forest Vet 9-14-05 Owings Mills, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARCH FUNERAL HOME-EAST M Q Wours adins 1101 E. North Avenue Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multi **Physician** Myeloma De disease or condition resulting in death) 115 /Medical Due to (or as a nsequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated exports Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 menths? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No detached 9 Unknown 9 Unknown signed by (23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 Probably 4 □Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy performed? certificate 1 ☐ Yes 2 No or Attending Physicien: director, Certification; To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Tes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No completely filled in by the t Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of cent ddess of person who completed cause of death (Item 23a) (Type, Print)
Robert Vissing, MD 2109 30. Name and Bastern Ave Baltimore 35 issing, MD 3509 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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			Decedent's Name (First, Middle			1. • 1.00		2. Date of D	eath	3. Time of Death
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	uneral Director		5. Social Security Number 214-56-3195 Usual Residence of Decedent	6. Sex 7. A	ge (In yrs. last birthdi 53 Yrs	Months Days	Hours Min	. (Month, D	23 51	Birthplace (State or Foreign Country) MD
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deat	E E	Funeral	11. Marital Status	12. Was Decedent	t Ever in U.S.	3. Was Decedent of H		Specify Yes or N	o- 14. Race -	American Indian, White, etc.
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ō =	E 5		Carolyn Jame 20a. Method of Disposition	2-MILE	20b. Place of Di	sposition (Name of		Date	20c. Location - C	
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Baltimore, Maryland 21215-0036	Department Important: I any Injury o		21. Signature 1 Funeral Service		1 2071	22. Name and Addre	ss of Facility H West		1	
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Division of Vital Records, P.O. Ior Attending Physician: The law requires that the d	ete hes been pege 2 shouk	Completed by	hypertension,dia	ibetes,hepat	itis C			24a. Wa auto peri	opsy pre	ere autopsy findings available or to completion of cause of ath?
in Tar	certificete rector, pe	ပိုင်	25. Was case referred to medica				/-		2□ No 0	Yes 2□No
of Vita Physician:	is certific director,	To B	examiner? 1 Types 2 No	Hoepital:	ient 2 ER/Outpa	tions 30 DOA Oth	00	eath Check only	one/ sidence 6 □Other	(04)
o of	= ₹		27. Manner of Death	28a. Date of Inj	jury 28b. Tim	e of unk 28c. Injur		28d. Describe	how injury occurred	1
ion	death. tor; After the funer	atio	1 □Natural 5 □ Pendir 2 Accident investi			y M 1 🗆	k? Yes 2∭XNo	trachea	and colo	on perforated procedures
Vis		Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be 28e. Place of Ir	njury - At home, farm,	street, factory, office		28f Location	(Street and Number	or Bural Bouta Number
ta Di	rs after al Dire ed in b	Çe		hognit	- 1			Hospita	wn, State) Johns 11,600 N.	olie Street,
To the Hospital	within 24 hours and to the Funeral completely filled	Medicai	29a. Certifier 1☐ Certifyir (Check only one) 1☐ Certifyir 2☐ Medical	ng Physician: To the bes Examiner: On the basis and manner s	of examination and/o	eath occurred at the tir r investigation, in my o	ne, date and place pinion, death occ	ce, and due to the curred at the time	cause(s) and mann date and place, and	er as stated. d due to the cause(s)
To th	withir To th comp	M	29b. Signature and title of certifie	r	^	29c. Licens	e number		29d. Date signed (Month, Day, Year)
	Jel.		Lashar	Mee	2 un	O.C.M	.E.		September	06, 2005
cho	All A		30. Name and address of person	who completed cause of	death (Item 23a) (Ty				1	,
() A	(0)		Tasha Z Greenbu		111 Penn	Street, Ba	ltimore,	Maryla	nd 21201	
	Sta		31. Date filed (Month, Day, Year)		trar's Signature	e & w				
	Regist	i i	SF	P 1 3 book	1900000	di Sopeti	5			

			State of Maryland / Department of Health and last State of Registrer State of Maryland / Department of Health and last State of Registrer	Mental Hygi	ene 2005	29717
			1. Decedent's Name (First, Middle, Last)	2. Date of Death	1	3. Time of Death
	Physicia /Medic		Georgia Ann Justice	Month September	er 9, 2005	7:35 A ^M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat		4c. County of Dea	th
			Futurecare Homewood 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs	B. Date of Birth	N/A	thplace (State or Foreign
	Funeral Director		212-18-6568		Year) Co	inplace (State of Foreign ountry) irginia
	ס		Usual Residence of Decedent	10011 0	1)47 V.	
	show	5	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1X1Yes 2 □ No
	the N	Director	Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code	10	g. Citizen of What Co	
	3a or	<u> </u>	633 N. Aisquith Street, Apt. 15L 21202		USA	outiny.
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Ame	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel", or items 23a or 26e-f show any injury or other treumatic event. The Modest Examiliation and once.	by Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 Yes 2 No	to nican, etc.)	Black, Whit	Black
у О	72 hc	Completed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of wo.	rking 1	6b. Kind of Business	/Industry
12	within ane. then	dm	Elementary/Secondary (0-12) College (1-4or 5+)		D 01	
	filled Hygie other	Be Co	11 Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name	me (First, Middle, M	Dry Cle	aning
<u>la</u>	uld be Aental rked o tic eve	To B	UNK. UN	К.		
Maryland	2 should and Men is marke eumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Re	ural Route Number,	City or Town, State,	Zip Code)
≥ 6	1 and Health em 27 ther tr		Quine 11 Sheppard/Granddaughter 2419 Maryland Avenue 20a. Method of Disposition (Name of	Baltimo Date 2	re, Mi) 212	218
nor	Pages nent of bent: if ite		1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place)			
Baltimore,	permit. Page Department importent: if any injury o	1		10/05	Baltimore	e, MD
B	permii Depar impor any ir once.		21. Signatur Frieral S rvice Geensee 22. Name and Address of Facility Cremation Society 299 Frederick Roa	of MD,] ad Baltimo	Inc. ore, MD 21	228
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial shock, or heart failure. List only one cause on each line.	c or respiratory arre	st,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Remail Fauluse b.			
	Examiner		Due to (or as a Vonsequence of):			
		Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	0.		
<i>y</i>	nd nd transif	Examiner	causé. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of)	Deare		
60,	icate be executed physician and s the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Curving Due to (or as a consequence of): Curving Due to (or as a consequence of):	ident		
68760,		edical	d	700		
Box (death certifi e attending id for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of de	
P.O. E	0 0 0	Physician/M	1 □ Pes 12 Thoritis? 1 □ Pes 2 □ No 9 □ Unknown 4 □ Pregnant at time of death 5 □ Other (specify)		Month	Day Year
	8 5 6	by P	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ord	w require s been sig should b		Perphial Vasantan Diseare	1 ☐ Ye	s 2 □ No 3 □ Pi	robably 4 @Unknown
Vital Records,	9 7 9	Completed	Tonarem	24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of
/ita	Physicien: Th r this certificate ral director, pag	Be (examiner?	ath (Check only one		
of	shys this al dii	. To		dome 5 Resider	nce 6 Other (Spe	cify)
O	ding th. After funer	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	20d. Describe no	w injury occurred	
Division	Attending or death.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office		eet and Number or R	ural Route Number,
ā	rs after or rel Dire	Cert	4 ☐ Homicide Building, etc. (Specify)	City or Town	, Siale)	
	To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer.	edical	29a. Certifier t☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one) 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	e, and due to the ca urred at the time, da	use(s) and manner as te and place, and due	s stated. e to the cause(s)
	To the lawithin 2.	Me	29b. Signature and title of certifier 29c. License number		d. Date signed (Mont	h, Day, Year)
)	2		1 / Jalta mD 1 31464		7/7/	0 7
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHOALLS A. HASHMIMD 821 N. EUTAKO ST Line	te 208 s	3ALTIMO,	12E MD 2120
	Sta Regist		31. Date filed (Month, Day, Year) SEP 1 3 2005			
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		1	For State Registrar	State of Marylan	id / Depa <i>Cer</i>	irtment of I <i>tificate of</i>	Health and I <i>Death</i>	Mental Hygie _{Reg}	ene 2005	29718
١	Physici /Medio		1. Decedent's Name (First, Middle, Las Patricia	t)	Kir	kner		2. Date of Death Month September	r 11, 2005	3. Time of Death 12:20 PM
	Examin Funeral Director		4a. Facility Name (If not institution, give 400 Symphony Circ 5. Social Security Number 6. S 215-48-7394	le #244D	last birthday) Yrs.	Hunt	Valley If Under 24 Hrs. Hours Min.		4c. County of Death Baltimo (ear) 1947 Ma	
	ס	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimo	10c. Cit	y, Town or Lo	/alley				10d. Inside City Limits 1 ∐Yes 2 🛣 No
36	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other than "natural", or iteme 23a or 28e-f ehow aumatic event, the Medical Expriner must be codified at	by Funeral Dire	10e. Street and Number 400 Symphony Circ 11. Marital Status 1 Never Married 2 Married 3 V Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	İ	Vas Decedent of Yes, specify Cub	Hispanic Origin? (S ean, Mexican, Puert		U.S.A. 14. Race - Ame Black, White Specify:	ncan Indian, a, etc.
Maryland 21215-0036	filed within 72 hou Hygiene. other then "neture ent, the Medical E	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	ucation	(Give i	ent's Usual Occup kind of work done OO NOT use retire	during most of wor id) iger	king	b. Kind of Business/County Gov	
laryland	2 should be f and Mental b ie marked of reumatic eve	To Be	Thomas H. 19a. Informant's Name/Relationship (1		Kand Number or Ru	ay L. Iral Route Number, C	Corl	
Baltimore, N	permit. Pages 1 and 2 should be Department of Health and Menta Importent: if Item 27 ie marked any injury or other traumatic ev		Dennis Kirkner 20a. Method of Disposition 1 XBurial 2 Cremation 3 C 4 Donation 5 Other (Specification)) Mor	Place of Disposemetery, crem	sition (Name of natory or other pla 1em. Park	9-15	Date 20	Mall, Ma c.Location-City or arkville,	20.200
Balt	permit. Departs Import any inj			ega.	10	Name and Address	Road T	owson, Mar	yland 21	Home, Inc. 204
68760,	Physician and physician and physician and physician and physician are the burial-transit	edical Examiner	23a. Part1. Enter the disease, or composition, the control of the	a. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uence of):	astases	all ell			Approximate Interval Between Onset and Death 3 - 4 Man
P.O. Box 6	The lew requires that the death certific ste has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	Ectopic pregnanc Other (specify)	у		23d. Date of deli Month	very Day Year
ords, P	w requires thet been signed b should be deta	ρ	Part II. Other significant conditions o	ontributing to death but not res	ulting in the un	derlying cause gr	ven in Part I.		2 □ No 3 Pro	the cause of death?
tal Rec		e Completed	25. Was case referred to medical				26 Place of Dea	24a. Was an autopsy performed 1 Yes 25	d? prior to death?	topsy findings available completion of cause of
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completaly filled in by the funeral director,	Certification: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not by		28b. Time of Injury	28c. Inju Wo M 1	ner: 4 🗌 Nursing H	ome 5 Residence 28d. Describe how	injury occurred	
Ω	Hospital or Al		4 Homicide determined	28e. Place of Injury - At he building, etc. (Specifician: To the best of my known and the best o	(y)		mo, data and alace	City or Town, S		
	To the Hoe within 24 ho To the Fun completaly	Medical	(Check only 2 Medical Examone) 29b. Signature and title ol certifier	and manner stated.	ition and/or inv	estigation, in my	opinion, death occu	rred at the time, date	and place, and due	to the cause(s)
	615		30. Name and address of person who	completed cause of death (Iter	n 23a) (Tune 1	D16	5P7		Sept. 12,	2005
6	ا الر		31. Date filed (Month-Day, Keath of	2 Pegistrar's Signal	OJan J	37/12 , S	£302,	Settinie,	MD 212	64
5	Sta Registi		SEP 13 20	JUS JUST STORY	S. Sall	S. C. L. C. C. C. C. C. C. C. C. C. C. C. C. C.				

State of Maryland / Department of Health and Mental Hygiene 2005 29719 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death r 11, 2005 **Physician** Month Keller Renee Harriett September 1:47 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Greater Baltimore Medical Center Towson Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months Days Hours 1 □ M 2 🗙 F New Jersey Yrs. Director 83 140-10-2801 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and to Health and Mental Hygiene and the Titem 27 is marked other than "natural", or items 23a or 28a-1 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Modical Examiner point be notified at Be Completed by Funeral Director 1 ☐ Yes 2X No Glen Arm **Baltimore** 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21057 11630 Glen Arm Road USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chief Library Technician U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Keller Unknown Domamski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randy Heller / Friend 4110 Halifax Court Glen Arm, Maryland 21057 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State injury or tment ant: If Hilltop Service Corp 9/15/05 * 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland permi Departn Imports any inju 21. Signature of Funer A Service L 22. Name and Address of Facility 1050 York Road Can Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part1. Enter the disease shock, or heart failure. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** NTE KENAL /Medical Due to (or as a consequence of): **Examiner** EPTICEM, A Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed LUSTRIDIUM FFICILIE Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical EUMON IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? II BRILLATION 1 ☐ Yes 3 ☐ Probably 4 ☐Unknown ARDIAC FAILUR 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2) SAICLICIMA STNO 1 Yes 2 X No 1 Yes or Attending Physician: in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: Medicai Certification: To 1 Yes 2No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) s after death. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide filled Fo the Hospital within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) AMANA GUSACAN MU 30 Name and address of person who completed cause of death (Item 33a) (Type, (ROSSIZO HOS #159 -INh Date filed (Month, Day, Year) SEP 1 3 32. Registrar's Signature State 2005 Registrar

(eller, Renee

State of Maryland / Department of Health and Mental Hygien 2055 29720 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Loretta Kinnamon 2005 <u>September 11</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 8519 Greens Lane Baltimore | H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days | Hours | Min. August 15, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
Ohio **Funeral** 1□M 24 F 280-12-2657 91 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location rthen "natural", or Itame 23s or 28s-f ehow the Medical Examinar must be notified at 10d. Inside City Limits 1 Yes 2 No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8519 Greens Lane 21244 United States filed within 72 hours efter death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes X No Specify: þ XXWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) at Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12th Salesperson Real Estate permit. Pages 1 and 2 should be like Depertment of Health and Mental Hy Important: If Item 27 ie marked other any Injury or other traumaits arows 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Lupo Marie DelVecchio 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) 10145 Green Clover Drive Ellicott City, MD 21042 Mrs. Cheryl Fee 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Mt. Comfort Cremator or other place) 2005 Alexandria, Sept.13, *4 ☐ Donation 5 ☐ Other (Specify) Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loring Byers Funeral Directors, In M60 333 8728 Liberty Road, Randallstown, Maryland 21133 23a. Parl. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician cvere /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of physiclen and the burial-transit The law requires that the deeth certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 9 IF FEMALE: for use 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) the deteched 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 TYes 3 Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□ Yes 2 🔃 1 TYAS Physicien: 25. Was case referred medical 26. Place of Death (Check only on examiner? Hospital: Other: 4 Nursing Home 2 1 Tes 2 10 1 Inpatient 2 ER/Outpatient 3 DOA 5 Lesidence 6 Other (Specify) 27. Manny of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After To the Hospitel or Attending I within 24 hours efter death. To the Funerel Director: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature arro ocense number (Type, Print) +UUUUId Court Road Pikesi 30. Name and combleted cause of death (Item 23a) (Type, Print) uman 31. Date filed (Month, Day, Year) egistrar's Signature State costa 3 2005 Registrar

Registrar DHMH 17 Rev 1/200

State

29b. Signature and title of certifier

odore

3 2005

HE ODORE MIKING 31. Date filed (Month, Day, Year)

SEP

30. Name and address of person who completed cause of leath (Item 23a) (Type, Print)

nu

32 Registrar's Signature

29c. License number

111 Penn Street Baltimore, Maryland 21201

OCME

29d. Date signed (Month, Day, Year)

September 7, 2005

		-	For State Registrar		State of M	arylan	id / Depa	artme rtifica	nt of He te of D	ealth and Death		Reg. No.		
	Physicia /Medic		Decedent's Name	e (First, Middle, Last) EVELYN			KA	RR			2. Date of De. Month SEPTEMI	Day	, žear 10, ŽÕČ	3. Time of Death 7:30 Å M
}	Examin	ėr	LONG VI	f not institution, give st EW NURSING	HOME					MANCHES	STER		County of De	CARROLL
	Funeral Director		5. Social Security N 142-14- Usual Residence of	-7617 ¹	M 2 7. Ag	ge (In yrs. 81	last birthday) Yrs.	Months	Days	Hours Min.	8. Date of Bird Month Da DEC.12	192	3 9. B	irthplace (State or Foreign Country)
	yland 10w		10a. State	10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	e Mar	Director	MD	CARRO	LL		WEST	MINS	TER					1 ☐ Yes 2 No
	with th		10e. Street and Nu		IDT			10f. Z	p Code	01150		10g. Citi	izen of What (•
	death ms 23	Funerai	11. Marital Status	DESTONE COL	2. Was Decedent	Ever in U	.S. 13.	Was Dec	edent of His	21158 spanic Origin? (S	Specify Yes or No to Rican, etc.)	-	14. Race - Am	
920	within 72 hours after death with the Maryland ene. Than "natural", or tlems 23a or 28e-f show the Maulcal Examiner mant be natified at	þ	1 ☐ Never Marr 3 🏋 Widowed	ried 2 Married 4 Divorced	Armed Forces? 1 X Yes 2 If Yes, Give Year or Dates:		1	it Yes, sp 1 ∐ Yes		Specify:	to Hican, etc.)		Black, Wh	ite, etc. WHITE
5-0	natur	eted	(Spec	15. Decedent's Educ cify only highest grade	ation completed)		16a. Dece (Give	dent's Us kind of w	ual Occupa ork done di	tion uring most of wo	rking	16b. Ki	ind of Busines	s/Industry
N	T) To - ***	Completed	Elementary/Seco	ondary (0-12) 12 (First, Middle, Last)	College (1-4or	5+)	RECE		VIST				TER CLU	JB
	a d a d a d a d a d a d	To Be	MAX				SHRA			FANNIE				(UNKNOWN)
Mar	d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2			ame/Relationship (Typ PARKS / DAL	e, Print) IGHTER			-			u <i>ral Route Numbe</i> - WESTMII			
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Baltimore,	Pag ent ent: I t: I			☐ Cremation 3 ☐ Re 5 ☐ Other (Specify)	moval from State	, ,				ERY 9/11	1/2005	В.	ALTIMO	RE, MD
Balt	permit. Page Department of Important: If any injury or		Much	meral Service Light	uger		8	900	REIST	ERSTOWN		PIKE		., INC. , MD 21208
				the disease, or complicant failure. List only of	ations that cause cause on each i	d the deat ine.	th. Do not ent	ter the mo	de of dying					Approximate Interval Between Onset and Death
1	Pnysician /Medical		Immediate Cause disease or condition resulting in death)	on a	— Due to (or as	2 consec)-ene	+	ب	M(7	med so	3~;		y ears
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68760,	icate be physicia s the bur	edicai		٥										
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9	uires that the signed by Id be detac	by	Part II. Other signi	ificant conditions con	tributing to death i	but not res	sulting in the u	inderlying	cause give	n in Part I.				to the cause of death?
Records,	w requ	ietec				-					24a. Was			autopsy findings available
al Re		Completed									1 Yes	rmed? 2□No	prior to death?	completion of cause of
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Div	el or Atteno	Certification:	4 Homicide	determined	28e. Place of In building, e	tc. (Speci	fy)	reet, racto	ry, office		City or To			Rural Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funeral Cirector: Afte completely filled in by the fune	Medical (29a. Certifier (Check only one)	1 Certifying Phys	ician: To the besi er: On the basis and manner s	of examina	owledge, deat ation and/or in	h occurre ivestigation	d at the tim n, in my op	e, date and plac inion, death occ	e, and due to the urred at the time,	cause(s) date and	and manner a d place, and di	as stated. ue to the cause(s)
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	8		30. Name and add	Steven	mpleted cause of	death (Ite	m 23a) (Type,	1	4	ver	8- les 1	la.	m \ 103 +	ee2 2/074
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1 - For Stete Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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107	Maryland	show	te pe	

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth any injury or other traumatic event 2008.

-ocklear, Kathery

Baltimore, Maryland 21215-0036

Ph sician /Medical Examiner

as the burial-transit and been signed by the attending physicien should be detached for use as the buria Records, P.O. Box 68760 Division of Vital al or Attending P after death. I Diractor; After t To the Hospital o within 24 hours aft To the Funaral Di completely filled in

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Katheryn Elizabeth Locklear 4c. County of Death DEPTEMBER 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death GOOD SAMARITAN 1105 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 26, 1937 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours 1 ☐ M 2X F 217-34-6819 Yrs. 68 MD Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 902 Quantril Way 21205 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No þ Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 years Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John R. Anderson Gertrude Ewing 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4540 Greencove Circle, Egdemere, MD. 21219 Cathy Waszelewski Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition September 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery ' 4 ☐ Donation 5 ☐ Other (Specify) 2005 12, Dundalk, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each ine. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death UNKNOWN Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2□ No 1 🔲 Yəs 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 1 XNatural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 105 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of ceptifier 29d. Date signed (Month, Day, Year) 0018230 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOCH RAVEN HOULEVARD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month,

2005 32. Regi

MAKTIMORE, MD 21239

State of Maryland / Department of Health and Mental Hygien 2005 1 - For State Registra Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician SANORA 2002 /Medical 4c. County of Death 4h City Town or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HARFORD 1267110RTH BEN A If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Days Hours Min 1 □ M 2 🖾 F Yrs. Director 1ARCHA 218 P3 5900 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28e-f show the Medical Examiner must be nutified at 1 ☐ Yes 2 No Director MARYLAM HARFORE JARRITTSVILL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö (TORTH BE or Items 23a 1901 COAC 21087 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 2 should be filed within 72 hours after us and Mental Hygiene. 1 ☐ Yes 250 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: þ 3 Widowed 4 Divorced WHIT Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ST. CLA, R 127 RS RIVIR 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Donnell EOWARL ATTA 27 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any injury or other traum once. ROAD MARYLAND 1280111961 34VITESTAL LACLIRE UAVIO. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10 IARY'S EHURCH 4 Donation 5 Other (Specify) ZOOE 21. Sign Hure of Funeral Tryic Licens to 22. Name and Address of Facility HAS A.R BEL HARZI-23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): lateral **Physician** months disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) signed by the at d be detached for 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown plnods peeu 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No s certificate has b lirector, page 2 st 1 ☐ Yes 2 No To the Hospitel or Attending Physician: within 24 hours after death to the Funeral Director. After this certifica completely filled in house the completely filled in house. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27 Manner of Death 28b. Time of 28c. Injury at Work? Certification; 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month. Day, Year) 29c. License number 29b. Signature and title of certifier September 12, 2005 028030 Combilation 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COUNBLATED MO Johns Hopkins Hochital DAVIO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygieney 1 - For State Registrar 29725 Certificate of Death Decedent's Name (First, Middle, La. 2. Date of Death **Physician** Month 10AM 2005 90 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 1502 Frederick Rd MARINERS 21228 a tousville 5. Social Security Number 7. Age (In yrs. last birthday If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1 ☐ M 2 🔀 F 91 Director 213-12-8410 16 MD Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 3819 West Coldpsring Lane 21215 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? , or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes X☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ፩ ₩ Widowed 4 Divorced "natural", Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "any Injury or other traumatic event, Ita Magnes. Elementary/Secondary (0-12) College (1-4or 5+) Laundry Worker Presser 8th grade na Fish Laundry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Thompson Maude Weems 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ida R. Cox-Daughter 3819 West Coldspring La, Balto, 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 9/10/05 Randallstown, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) av **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examiner burial-transit The law requires that the death certificate be executed attending physician end for use es the burial-trar resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death signed by the at id be detached fo 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 3 Probably Completed 1 Tyes 4 Unknown 24b. Were autopsy findin s alable prior to completion ause of death? 24a. Was an 30 1 ☐ Yes 1 Yes Division of Vital or Attending Physician: 25. Was case referred to medical examiner?

1 \(\sum \text{Yes} \) 2 \(\sum \text{Vo} \) Be Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a, Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending Injury deeth. investigation 1 ☐ Yes 2 ☐ No 2 Accident efter deeth 6 Could not be determined 3 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} To the Hospital o within 24 hours eff ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifie 32. Registrar's Signature State Registrar

			For State Registrar	State of	Maryland	d / Depa <i>Cer</i>	rtment tificate	of He	ealth a Death	and M	ental Hy	giene Reg. No	2005	29726
			Decedent's Name (First, Middle, Las	t)							2. Date of De			3. Time of Death
	Physic /Medi		Charles Martin	Lucas							Month Septeml		11, 2005	9:35 A M
	Exami		4a. Facility Name (If not institution, give	street and num	ber)	:	4b. City, T			of Death		4c. County of Death		
			1205 Mazeland Di				Be If Under 1	el A	ir If Under	04 400			Harfor	
	Funeral Director		5. Social Security Number 6. Se 1	3xM 2□F	'. Age (In yrs. Ia 8(V		Days	Hours	Min.	8. Date of Bir (Month, Da Sept.	ty, Year)	Coun	lace (State or Foreign try) nsylvania
			Usual Residence of Decedent								sept.	JU, 1	724 1011	isyivania
	arylar show	-	10a. State 10b. County		10c. City	, Town or Loc	ation						1	0d. Inside City Limits 1 ☐ Yes 2 ☐ X o
	the M	by Funeral Director	Maryland Harford 10e. Street and Number		B€	el Air	10f. Zip (Code				10a Cit	tizen of What Coun	
	3a or	<u>=</u>	1205 Mazeland Di	ciro				1015				Tog. Cit	USA	uyr
ío	death	nera	11. Marital Status	12. Was Deced	dent Ever in U.S	S. 13. W	/as Decede	ent of His	panic Ori	igin? (Spec	ify Yes or No)-	14. Race - Americ	
y	36 after or ite	F.	1 Never Married Married	Armed For 1 TYes If Yes, Give	2 🗆 No	1	Yes, speci		Specify:		iican, etc.)		Black, White,	etc.
400	21215-0036 Jwithin 72 hours after death with the Maryla Jiene. I'r than "natural", or items 23a or 28a-1 show The Modical Examilier reast be multilay at	q pe	3 ☐ Widowed 4 ☐ Divorced	Year or Da	tes:	16a. Deced						105 10	W	nite
7	115 in 72	plet	(Specify only highest gra	de completed)	45.)	(Give I	kind of work ONOT use	k done du	iring mos	t of workin	g	Me	ind of Business/Ind tal Extr	usion
	d 2121 filed within Hygiene. other than ant, the Me	Completed	Elementary/Secondary (0-12)	College (1-	40r 5+)	Facto	ory W	orke:	r			Ma	nufactur	er
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	Maryland 21215-0036 Id 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. It is marked other than "natural", or items 23e or 28e-1 show traumatic event, the Modical Exemples marked by Intilling at	2	Stephen (nmn) I	Lucas		105 11:25		/2:			(unk)			
	Ma id 2 s ith an 27 ls r traur		Jean E. Lucas /	Wife									or Town, State, Zip	Code)
0	s t ar f Hea itsm otha		20a. Method of Disposition		00	lace of Disposemetery, crem	ition (Nam-	e of		Da	ite All		21015 ocation - City or To	wn, State
3	altimore, mit. Pages 1 ar partment of Hea portent: If itsm y injury or otha		1	Removal from S	tate	ke Park	•		´ l .	9-15-	05	Young	gstown, (Ohio
Thank	Baltimore, Maryland 2- permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Importent: If itsm 27 Is marked other ta any injury or other traumatic event, In once.	j	21. Signature of Funeral Service Licen	see ()	= 1	22. N	Name and	Address	of Facilit	iy 1 Hor	me, P.	Α.		
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_	1440	H	23a. Part1. Enter the sisease, or comp shock, or hear faiure. List only immediate Cause (Final	one cause on ea	ch line.	Do not ente	r the mode	of dying	, such as	cardiac or	respiratory ai	rrest,		Approximate Interval Between Onset and Death
•	Physician /Medical		disease or condition resulting in death)	a. Me	or as a consequ	ali	cul	n c	u	ee			a.	
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	fs, P.O. I res that the de signed by the a	Phy	Part II. Other significant conditions of	entributing to de:	ath but not resu	ulting in the un	derhina ca	IISA GIVA	in Part I		23e Did to	obacco i	use contribute to th	e cause of death?
	Division of Vital Records, to Attanding Physician: The faw requirest after death. Director: After this certificate has been signed in by the funeral director, page 2 should be of the page 2.			ATT. 100 THE STATE OF THE STATE	2111 001 1101 1000		derlying da	use give	i iii r aiti.	•				ably 4 Unknown
	cord w requires been si	lete							_		24a. Was	an	24b. Were autor	osy findings available
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	ian: ian: italica	BeC	25. Was case referred to medical examiner?						26. Place	of Death	1 ☐ Yes (Check oлly d		117162	2010
	of V hysic his ce	70	1 ☐ Yes 2 🗓 No		patient 2 1	ER/Outpatient			4 🗆 140	irsing Hom	e 5 Besid	dence	6 □Other (Specify	')
	on C ling P	lon:	27. Manner of Death Natural 5 Pending	28a. Date of (Month)	f Injury , <i>Day Year)</i>	28b. Time of Injury	м 28	Bc. Injury Work			3d. Describe I	now injur	ry occurred	
	Division of Vital Re I or Attanding Physician: The I after death. Diractor: After this certificate ha	flcat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place	of Injury - At ho	me, farm, stre			es 2 🗍		3f. Location (5	Street an	id Number or Rura	i Route Number
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	Division of Vital Records, P.O. Box (To the Hospital or Atlanding Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atlending completely filled in by the funeral director, page 2 should be detached for use as	Medical (29a. Certifier Check only one) Certifying Ph	/sician: To the l iner: On the ba	sis of examinat	wledge, death tion and/or inv	occurred a estigation,	it the time in my opi	, date an nion, dea	d place, ar	nd due to the	cause(s) date and	and manner as sta d place, and due to	ated. the cause(s)
	To the within 2 To tha comple	Mec	29b. Signature and title of certifier	and maille			29c.	License	number			29d. Dat	te signed (Month, L	Day, Year)
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			30. Name and address of person who	completed cause	of death (Item	23a) (Type, F	Print)							000
	10		31. Date filed (Month, Day, Year)	אענו	6,5	W.A	1 400	カカ	.]	Rel	DIC,	Ma		
	St Regist	ate trar		2005 D	gigrar's Signat	A A	Sperit							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene O. O. F.

		1	1 - State Registrer	State of Maryland	Certificate of Death	id Mental i	Tygier Reg. I		29727
	Physicia	an	1. Decedent's Name (First, Middle, Last	oial		2. Date o	Death	Day Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of I	Death Dept	. 9	4c. County of Death	10:45
			Future Care 5. Social Security Number 6. Se	- Homewood	Baltima It birthday) If Under 1 Year If Under 24	Hrs. 18 Date of	Dieth	NA	lana (State or Foreign
	Funeral Director		218-31-0801 10	1 M 2 X F 46		Min. 8. Date of Month	Day Year	59 Ga	lace (State or Foreign itry)
	yland how		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location			1	Od. Inside City Limits
	death with the Maryland	Director	Maryland NA 10e, Street and Number	P	altimore 101. Zip Code		100	Citizen of What Coun	1 Yes 2 No
	th with 23e or	ai Dir	1010 Woods	on Rd.	21212		log. (Gamb	l A
	items items	Funerai	11. Marital Status 1 □ Never Married 2 ☑ Married	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	n? (Specify Yes o Puerto Rican, etc.	r No-	14. Race - Americ Black, White,	an Indian, etc.
3036	be filed within 72 hours after death with the Marylan lat Hygiene. Id other then "neturel", or items 23e or 28e-f show event, the Medical Examination and the nuffled at	by	3 Widowed 4 Divorced	1 Tes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 🗗 No Specify:			Specify: Afr	ican
15-(within 72 h ene. then "netu	Completed	15. Decedent's Edi (Specify only highest grad	cation de completed) College (1-4or 5+)	 Decedent's Usual Occupation (Give kind of work done during most o life. DO NOT use retired) 	f working	16b.	Kind of Business/Inc	dustry
1212	filed with Hygiene other the		Elementary/Secondary (0-12)	College (1-40f 5+)	Unemployed	N (5' 16'		NA	
lanc		To Be	17. Father's Name (First, Middle, Last)		14 SC	Name (First, Mic	odie, Maid	John	
Maryland 21215-0036	and and ie m		19a. Informant's Name/Relationship (7	100, Print) (day hter)	19b. Mailing Address (Street and Number of	or Rural Route Nu	ımber, Cit	y or Town, State, Zip	Code)
	ges 1 and it of Health if item 27 or other tr		20a. Method of Disposition		ce of Disposition (Name of netery, crematory or other place)	Date Date	20c.	Location - City or To	wn, State
Baltimore	Pa nen ant:		1 ⊠ Burial 2 □ Cremation 3 ☒ '4 □ Donation 5 □ Other (Specify	Mui		16/2005	B	anjul, G	ambia
Bal	permit. Departr Importe eny inji		21. Signature of Funeral Service Licens	L. Russ	A Name and Address of Stillity JOSEPH L. RUSS 2222 W. North	Funera	Ho	me, P.A.	
	Ų.		• /	~ ^ ^ -	Do not enter the mode of dying, such as ca	rdiac or respirato	ry arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	aDue to (or as a conseque		Ancre	AS		3 years
Į,	Examiner	<u>.</u>	Sequentially list conditions,	b	, , , , , , , , , , , , , , , , , , ,				
	outed Id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C.	nee orj.				
,09	eath certificate be executed attending physiclen and for use as the burial-transit		resulting in death) Last	Due to (or as a consequent	nce of):				
68760,	rtificate ng phys as the	Medicai	IF FEMALE:	d.				-	
Вох	leath ce attendi i for use	cian/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea	eath 3 ☐Ectopic pregnancy			23d. Date of delive Month	nry Day Year
P.O.	that the de led by the a detached	Physician/M	1 ☐ Yes 2 ☐No 9 ☐ Unknown	9□ Unknown					
	96	þ	Part II. Other significant conditions co	ntributing to death but not resulti	ing in the underlying cause given in Part I.		☐ Yes	o use contribute to th	ably 4 Unknown
Records,	law require las been si s 2 should b	Completed				a	Vas an	24b. Were auto	psy findings available inpletion of cause of
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of Vi	y	To B	examiner?		04	f Death (Check of		6 □Other (Specify	')
	ing After une		27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	8b. Time of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		ibe how in	jury occurred	
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	To the Hospitel or Att within 24 hours after d To the Funerel Direct completely filled in by		29a. Certifier 1 Deartifying Physics	/sicien: To the best of my knowl	edge, death occurred at the time, date and p	place, and due to	the cause	(s) and manner as st	ated.
	the Ho hin 24 I the Fu mpletely	Medical	one) 2 Medicel Exem	iner: On the basis of examinatio and manner stated.	n and/or investigation, in my opinion, death	occurred at the ti	me, date a	and place, and due to	the cause(s)
	o i¥ o o		29b. Signature and title of certifier	iney M	D00778	60	Se	plember 1	2th 2005
1	10		30. Name and address of person who c	ompleted cause of death (Item 2	(3a) (Type, Print) 10 2700 N. Chryles	e CL R	all.	MQ.Z	12.18
) Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signatur		Jr U	1/1.	110,0	1010
	Registi	ar	SEP 1 3 200	15 House M	Coast 1				

Norman Lazarowsky Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-06116 State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene G847 9-22-05 tas Certificate of Death RPD 29728 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** ZALIK LAZAROWSKY NORMAN 7, 2005 0947 A September /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Northwest Hospital Center Randallstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth NOV. 2, 1963 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Days Months Hours 41 Yrs MD 212-80-5362 Director Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or iteme 23a or 28a-f ehov Examinar must be notitled at 1 ☐ Yes 2 X No BALTIMORE BALTIMORE Direct the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? A P 21208 USA 18 WARREN PARK DRIVE #C-3 deeth Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💢 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 le marked other than "natural; or item eny injury or other traumatic event, the Medical Examines 9008. Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ELECTRICIAN ALGERS ELECTRIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LAZAROWSKY SONIA KATZ JOSEPH 1 4 1 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 18 WARREN PARK DRIVE #C-3 NANCY DORSEY / FIANCEE BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEM. 09/12/2005 BALTIMORE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Methadone Intoxication /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any lasting training actions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consumence of Examiner or Attending Physician: The law requires that the deeth certificate be executed and Due to (or as a consequence of): physicien a s the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: **PSP** 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Zunknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 → Yes 2 → No page 2 autopsy performed? 2 No 1XYes 2□No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 XXF/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To TXXYes 2 □ No this After the 28a. Date of Injury **Fortfith**, Day Year) **9-7-05** 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred unk 5 Pending Found 8:05 1 Natural death. investigation 1 ☐ Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 18 Warren Park Dr. 4 Homicide Scene Pikesville, 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

within 24 hours after death To the Funeral Director: completely filled in by the t Hospital

> State Registrar

31. Date filed (Month, Day, Year) SEP 1 3 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RUBIO

29b. Signature and Litle of certifier

HD. 2. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

September 8, 2005

			Please							-		
		1 _ For State		State of	Marylar		artment of F rtificate of		Mental Hyg	711	05	29729
	_	Registrar 1. Decedent's Name (i	First, Middle, Las	t)			Tillicate Of	Dealii	2. Date of Dea	ieg. No.		3. Time of Death
	ician	Eliza		Mulk	alla	ad			Month	Day	Year	320 AM
	dical niner	4a. Facility Name (If no				9 79	4b. City, Town, o	r Location of Dea	sept.	4c. County		
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Fune	_	5. Social Security Num	ber 6. Se	ex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hr Hours Mi	n. (Month, Day	Year)		ce (State or Foreign
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th the or 28	Director	10e. Street and Number					10f. Zip Code		1	l 0g. Citizen of 1	What Countr	
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.O. Box 68 the death certifica y the attending ph ched for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pr	regnant	23c. If yes, out	come of pregnanth 2 Peta		Textonio escapa-			23d. Da	te of delivery	
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			V						perform 1 Yes 2		death?	□ No
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Division To the Hospital or Attention within 24 hours after deatl To the Funerel Director: completely filled in by the	edical	(Check only 2	Certifying Phy Medical Exam	sicien: To the	best of my kno	wledge, deat	h occurred at the tin	ne, date and place	ce, and due to the ca curred at the time, da	ause(s) and ma	inner as state	ed.
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To th Within	₩	30. Name and address	M	completed cause	of death (Iter	n 23a) (Type,	Print)	2164	ns Aus	RAI	TIMM	2005
	State	30. Name and address A.A. 31. Date filed (Month,	s of person who c	3A 51	e of death (Item	Wig	Print) Print)	2164 Jelke	ns Avi	BAL	TIMOG	2005 15.402129

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (Eirst, Middle, Last) 2. Date of Death Month **Physician** MOORE ember 0, 200 /Medical 4a. Facility Name (If not institution, pile street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NOVa Ridge oad Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F 616 Yrs. Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 77 is marked other than "natural", or items 23a or 28e-f show traumatic event, the Madical Examiner must be notified at 1 Yes 2 □ No Director etimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Noodridge 3929 Completed by Funeral 12. Was Do 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Blac 1 ☐ Yes 2 No 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. importent: if item 27 is marked other than "na any injury or other traumatic event." John Hupke Elementary/Secondary (0-12) College (1-4or 5+) HOS PITAL 10th 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) ESSIE. Willie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 518 mr. Holly St. Balto. moore 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State etimore Nat 12 JERT 12, 2005 Baetimine 4 ☐ Donation /5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Suneral Service Licens editition Pass march 23a. Part V. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or read at a little only one cause on each line. Approximate Interval Between Immediate Gause (Final disease or condition resulting in death) Onset and Death **Physician** Lal Myocard /Medical Due to (or as a consequence of): Examiner Cheral ascalar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine by the attending physician and tached for use as the burial-transit (6 The law requires that the death certificate be executed End Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 20 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 2 2 10 24a. Was an autopsy performed? To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifical completely filled in by the funeral director, p. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar

2HUCKIFIE 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Rose coeffe who word

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 2005

TROM AS MID

32. Registrar's Signature

4000 WEST NEATTERN PKY, BALTIMORE, and 21215 frede

142683

29d. Date signed (Month, Day, Year)

September 7th 2005

State of Maryland / Department of Health and Mental Hygiene $2\,0\,0\,5$ 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Necy Day 199150n Year Month **Physician** 2005 9 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Boltimore Hos 21091 If Under 1 Year | If Under 24 Hrs. 8. Birthpface (State or Foreign Country) 5. Social Security Number 6. Sq 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours 212 1 ☐ M 2 🗵 F 151 Director NOU, 15, Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or itams 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic svent, the Medical Examiner must be notified at once. T⊠Yes 2 No Be Completed by Funeral Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 121 Was Decedent Ever in U.S. Armed Forces?, 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during prost of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cas 12-11 (010 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas oates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Back, md. 2,215 Son 5032 bembridge to WILTON. madi. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 9-13-0 Crematory metro 4 ☐ Donation /9 ☐ Other (Specify) 21. Signature of F neral Selvice Licensel 22. Name and Address of Facility 270 fred HILTON Bareto, mg. 21229 march Frineral Home 23a. Party Eor rune disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or earl failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate on se (Final disease or condition resulting in death) **Physician** Thero sclerctiz /Medical Due to (or as a consequence of): Examiner pertensich CAN if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed accide. as CC 09.17 to (or as a consequence of) P.O. Box 68760, physician IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetaf death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Munknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 🗖 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3K DOA this 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of After 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 2 🗆 No investigation 1 Tyes 6 Could not be determined 3
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 12 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Magem 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) acem 501 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 20051 - For State Registrar 29732 Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death 23, 200 B **Physician** AUGUST 7:00F Irvin McQuay /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Baltimore 4b. City, Town, or Location of Death **Examiner** Saint Joseph Medical Center Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min **X**□M 2□F Yrs Director 216-28-9697 73 Md. Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 28e-f show other treumatic event, the Mudical Examinar must be nutified at XIN Yes 2 No Director Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 3806 Dorchester Road 21207 'neturel', or items 23e Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√ No If Yes, Give⁴ Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Laborer Unknown permil. Pages 1 and 2 should be filed a Department of Health and Mental Hygie Importent: If Item 27 is marked other t any injury or other treumatic event. In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Unknown Unknown 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) R/N 3039 Hamilton Ave., Baltimore, Md. 21214 Sarah Williams 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State X□ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Carmel Cem. 9-13-05 Dundalk, Md. Mt. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21202 Baltimore, Md. lady Wane March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ANOXIC BRAIN INJURY DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner DAYS ACUTE RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed YEARS c DIABETES MELLITUS and Due to (or as a consequence of) burial-t physician a P.O. Box 68760, Physician/Medical ast the attending IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 DEctopic pregnancy ō in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown signed by det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by þe 2 X No 1 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 Yes 2 the Hospital or Attending Physician: 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) 21 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Magner of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Division 1 Natural 2 Accident 5 Pending investigation t Director: A birector: A in by the fu 1 Yes 2 No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a
To the Funerel C
completely filled filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 D0025886 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CEBALLOS, M. D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 ILIA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 3 2005 SEP Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2.0.0 F.

	1 - For State Registrar	State of Maryland /	Certificate of Death	Reg.	
Physician /Medical		MITH	MORRISON	Sept (Day Year 3. Time of Death 9:32 AM
Examiner	4a. Facility Name (If not institution, give	street and number) Bultim Ended Case Co	ter BALTIMORE		4c. County of Death NA
Funeral Director	5. Social Security Number 6. Sec. 205-24-1961	7. Age (In yrs. last I	oirthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min.		9. Birthplace (State or Foreign Country) N.J.
yland	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location		10d. Inside City Limits
Mar Mar Mar	Md. NA	E	altimore		11 Yes 2 □ No
or 28	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
ath w	505 S. Lehigh	Street	21224		USA
and 21215-0036 be filed within 72 hours after death with the Maryland tital Hygiene. so other than "naturel", or Items 23a or 28a-f show event, the Modical Exertiner matter nutified at Be Completed by Funeral Director	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 Yes ZE No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
5-0 72 ho	15. Decedent's Edu (Specify only highest grad	cation 16	a. Decedent's Usual Occupation (Give kind of work done during most of wo	ding 16b	. Kind of Business/Industry
Taryland 21215-0036 2 should be filed within 72 hours att and Mental Hygiene. Is marked other than "naturel; or eumatic event, the Modical Exertal To Be Completed by F	Elementary/Secondary (0-12) 9th grade	College (1-4or 5+)	life. Do NOT use retired) Laborer	rking	Varies
be file tal Hyg d othe event,			18. Mother's Na	me (First, Middle, Maid	(en Sumame)
Maryland of 2 should be file tith and Mental Hy 27 is marked oth traumatic event	Ernest	Bask	in Cecio	il	Harris
2 sho and ls my	19a. Informant's Name/Relationship (Ty		b. Mailing Address (Street and Number or Ri		
iore, Maryla ges 1 and 2 should t of Health and Men if Item 27 is marke or other traumatic	Delores Hamm	Care Giver	505 S. Lehigh St	-	
Pa Pante ury	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)	Removal from State Ceme Md.	tery, crematory or other place)		Crownsville, Md.
Baltim permit. Pa Departmen Important: any injury once.	21. Signature of Funeral Service Licens	p Waner	22. Name and Address of Facility March F.H. Eas	Balt:	imore, Md. 21202 E. North Ave.
68760, ifficate be executed with a physician and as the burial-transit as the burial-transit edical Examiner	if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	e of):		Onset and Death
ords, P.O. Box 68' requires that the death certificat een signed by the attending phy rould be detached for use as th sted by Physician/Medi		3c. If yes, outcome of pregnancy 1 □Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown	th 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
rds, P. quires that n signed by lid be deta	Part II. Other significant conditions con Diabetes Me	ntributing to death but not resulting	in the underlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
The taw The taw ate has b page 2 st	Hypertension			24a. Was an autopsy performed 1 Yes 2 X	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Vital sicien: T certificat irector, pa	25. Was case referred to medical	1		ath (Check only one)	
Jn O ding Pl	10 165 2210	P. I	Outpatient 3□ DOA Other: 4□ Nursing F . Time of Injury 28c. Injury at Work? Injury M 1□ Yes 2□ No	lome 5 ☐ Residence 28d. Describe how in	
Division c tral or Attending P ts atter death. al Director: After ted in by the funera Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
Divisic To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the Medical Certifical		sician: To the best of my knowled ner: On the basis of examination and manner stated.	ge, death occurred at the time, date and place and/or investigation, in my opinion, death occu	a, and due to the cause arred at the time, date a	o(s) and manner as stated. and place, and due to the cause(s)
within 2 To the complet	29b. Signature and title of certifier		29c. License number	29d. [Date signed (Month, Day, Year)
- > - 0	1	mD	056508	ت ا	Sept. 08 2005
. Q	30. Name and address of person who co		(Type, Print) XIANGROVG	mo.	A STATE OF THE STA
111.2	3900 LOCH R/	4 VEN BLV. 32 Registrar's Signature	BALTIMORE	mo.	21210

State of Maryland / Department of Health and Mental Hygiene 2005 29734 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year 9 2005 /Medical September 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital Bottmare Cuty
If Under 1 Year If Under 24 Hrs. Months Days Hours Min. N/A 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 107-40-7835 1□ M 2🙀 F 53 1474674954 NEWYORK Director Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits other traumatic event, the Medical Exempler must be notified at Directo BALTIMORE TOWSON 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Iteme 23s 3 GOUCHER WOODS COURT 21286 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ WHITE Specify 3 ☐ Widowed 4 ☐ Divorced "neturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 72 h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) YEARS CLAIMS ADJUSTER **INSURANCE** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 MARVIN FEDER RHODA MALKIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s if Health an LARRY MILLER/ HUSBAND 3 GOUCHER WOODS COURT TOWSON, MARYLAND 21286 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite any injury or ot once. PARKWOOD CEMETERY 1 Removal from State 9/11/2005 BALTIMORE CITY * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME P.A. 21. Sign yur yof Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MARYLAND 21286 23a. Jar1. Enter the disease, or complications that caused the feath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) theumonia Iweek /Medical Due to (or as a consequence of): Examiner (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed use as the burial-transit ALTOLOGOUS that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical 3 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by pe 1 TYes 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? Yes 2 No certificate 1 ☐ Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pendina within 24 hours after death.

To the Funerel Director: A completely filled in by the fin investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of eertifier 29c. License number 29d. Date signed (Month, Day, Year) Medical Poctor Res 000 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boltimore 10 NWance. The Johns Hopkins tospital, was North worker 21287 31. Date filed (Month, Day, Year) 32 Registrar's Signature State SEP 1 3 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland 7 Department of Health and Mental Hygiene 2005 29735 For State Registrar Certificate of Death Rea. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav 5:00 2005 Sep. Aldona Marcinkus 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Balzemore inden Baltimore Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number Days Hours Min. 1 ☐ M 2 🕱 F Yrs. 21, Lithuania 76 213-30-7816 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 🙊 🔀 No Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 4413 Linden Ave. 21227 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 257 Married 1□Yes 2♀No Specify: white Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Scskunas John Majauskas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Antanas Marcinkus - Husband 4413 Linden Ave. Baltimore, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery Sep. 8, 05 Baltimore City • 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signatur 1 Funeral Service L 3620 Wilkens Ave. Baltimore, Maryland 21229 Approximate Interval Between Onset and Death d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Par 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ral, or itams 23a or 28a-f show Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or Items 23a eny injury or other traumatic event, Ita Moulcal Exempter 20068.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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MD

with the Maryland

within 24 hours after death To the Funeral Director: / completely filled in by the f

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

death.

	disease or condition	rancre	MIL CH				
	resulting in death)	Due to (or as a conseq	uence of):				
liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a conseq	uence of):				
cal Exan	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):				
Physiclan/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes; outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	I death 3 Ectopic pregr			23d. Date of delivery Month Day	Year
þ	Part II. Other significant conditions con	tributing to death but not res	ulting in the underlying caus	e given in Part I.	23e. Did tobacc	co use contribute to the car 2 No 3 Probably	
Completed					24a. Was an autopsy performed		ion of cause of
a	25. Was case referred to medical			26. Place of De	ath (Check only one)	1-cno	
To B	examiner?	lospital: 1 Inpatient 2	ER/Outpatient 3 DOA	Cther: 4 Nursing	Home 5X Residence	6 ☐Other (Specify)	
	27. Manner of Death 1 (2) Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury M	Injury at Work? 1 Tyes 2 No	28d. Describe how in	njury occurred	
Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, tc. (Special	ome, farm, street, factory, o	fice	28f. Location (Street City or Town, St	t and Number or Rural Rou tate)	ute Number,
Medical C	29a. Certifier (Check only one)	sician: To the best of my known or the basis of examination and manner stated.	owledge, death occurred at a total and/or investigation, in	he time, date and place my opinion, death occ	ce, and due to the cause curred at the time, date	e(s) and manner as stated and place, and due to the	cause(s)
Me	29h Signature and title of certifier		29c. L	icense number	29d.	Date signed (Month, Day,	Year)

State Registrar

14

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4660 Wilkers Are Bat Einere



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 29736 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 12.05AM MCGRNICK EILEEN 5°EP 2005 /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Brightwood Center Lutherville Baltimore If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 M 2 XF Yrs. 220-52-2612 Director JAN 31, 1932 **England** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or hems 23s or 28s-f show ury or other traumatic event, the Medical Examinar must be notified at 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Funeral Director Baltimore Maryland Cockevsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13 Laurelford Court 21030 United Kingdom Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify White à 3 X Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Sales Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rose Higgins William Kennedy Ch Mailing Address (Stort and Number of Rysal Route Number, City or Town, State, Zip Code)
Chemiat Tons Society of Maryland, Inc. 19a. Informant's Name/Relationship (Type, Print) 299 Frederick Road Baltimore, MD 21228
Date 20c. Location - City or Town, State Janice Kathleen White/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of important: If it any injury or o 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metro Crematory, Inc. 9/12/05 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Cremation Society of Maryland, Inc. 21. Signature of Funeral Service License Dawn F. McDonald 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final diseese or condition resulting in death) /Medical DEMENTIA Examiner Due to (or as a consequence of) edical Certification: To Be Completed by Physiclan/Medical Examiner Hospital or Attending Physician: The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 20 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending 1-Natural s efter death. ii Director: Aft ad in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours e To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0053150 SEPT 1247 2005 Geath (Item 23a) (Type, Print)
COUPTA 96505ANTIAGOKOAD COCUMBIA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar **DHMH 16 Rev 6/95**

State

21045

32. Flegistrar's Signature

5 h ALWNYALA

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene ? 29737 1- State Amend Item 5 per fh G847 9-16-05 rt Freate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 11:58 AM SEPTEMBER 11, 2005 Pauline E. Mack /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Country) | Aug. 11,1914 | Maryland 7. Age (In yrs. last birthday) 2536<u>V</u>0605 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M XX Yrs. 91 Director Usual Residence of Decedent the Maryland 10b. County 10a. State 10c, City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner roughter at 1 ☐ Yes 2 XXIo Director MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 306 Cantata Ct. Apt. 121 21136 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes X X No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-iff Yes, specify Cuban, Mexican, Puerto Rican, etc.) e filed within 72 hours after di if Hygiene. other than "natural", or item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Black Completed by XXWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 Colfege (1-4or 5+) House Keeping Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental b is marked of Charles Edgar Chester ၉ Sadie Avon Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any Injury or other traum once. Janice A. Wicks /Daughter 218 Mid Pines Ct.; Apt.1-D; Owings Mills, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State XXBurial 2 ☐ Cremation 3 ☐ Removal from State Baltimore National 9/16/05 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 3/10/05 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Frineral Service Licens 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Physician PULMONARY EMBOLUS /Medical Due to (or as a consequence of): Examiner ANEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ur as a consequence of) Examiner anding physicien and use as the burial-transit c. DEMENTIA Due to (or as a consequence of): Box 68760 ATRIAL FLUTTER Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetat death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No for Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part If, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ ete has been signe page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2K No Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 🗓 Inpatient 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 5 Pending 1 XNaturaf death. М 1 Yes 2 No investigation after death filled in by the t 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of co 29c. License number D 8944 05 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person DRIVE, TOWSON, MARYLAND 21204 M. D. 76 32. Registrar's Signature CHRISTINE BOUTZALE 7601 31. Date filed (Month, Day, Year) State The Contract 2005 3

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Registrar

		•	St State Registrar	ate of Maryland / D	epartment of H Certificate of L			ene 2005	29738
	Physici /Medic		Carrent	la R.	Micha	eel s	2. Date of Death Month September	Day Year 7005	
	Examin		4a. Facility Name (If not institution, give street The Johns Howins Hos	and number)	Baltino	Location of Death	/	4c. County of Deat	h
	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In yrs. last birth	nday) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, May 28,	Year) 9. Bin 1908 Mai	hplace (State or Foreign ountry) YLand
	show	ō	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town					10d. Inside City Limits 1 ☐ Yes 2 🛣No
	28e-f	rect	Maryland Harford 10e, Street and Number	Aberde	10f. Zip Code		10	Og. Citizen of What Co	puntry?
	3e or	Funeral Director	505 Richards Lane		21001			USA	
	ems 2	ner	11. Marital Status 12. V	/as Decedent Ever in U.S.	13. Was Decedent of Hi	ispanic Origin? (Spe In, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
9000	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hyglene. item 27 is marked other then "naturel; or Items 23e or 28e-1 show other treumetic event, The Medical Examble months be notified at	by		rmed Forces? □Yes 2 X No Yes, Give ear or Dates:	1 ☐ Yes 2X No			Specify: V	Mite
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	filed w Hygier other th		17. Father's Name (First, Middle, Last)		Owner/Opera	18. Mother's Name		Grocery Fo)OG
Maryland	should be filed nd Mental Hygi i marked other umetic event, I	To Be	James Hamlin	Riley		Mary	Ellen	Henders	
Mar	id 2 should lith and 27 is mutterment		19a. Informant's Name/Relationship (Type, F		Mailing Address (Street a				ZIP Code)
Ē,	pes 1 and of Health If item 27 or other tr		James T. Weber - Per 20a. Method of Disposition	20b. Place of	Disposition (Name of crematory or other place	D.		20c. Location - City or	Town, State
<u>ii</u>	Pag ment ent: ury		1X Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)		Presby. Ch.	Cem. 9/12		berdeen, M	
Baltimore,	permit. Pag Department Importent: I any injury o once.		21. Signatur of Funds Service Licensee			sbury Road	d, Abing	uneral Hon don, Maryl	
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complicatic shock, or heart failure. List only one cal Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury	Due to (or as a consequence of the total conse	va va	y Fall	bre	ist,	Approximate Interval Between Onset and Death 30 minutes
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O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/M	23b. Was decedent pregnant in the past 12 months?	yes, outcome of pregnancy Live birth 2 Fetal death Pregnant at time of death Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of de Month	ivery Day Year
٦	uires that t n signed by	þ	Part II. Dther significant conditions contribu	ating to death but not resulting in	the underlying cause give	en in Part I.	23e. Did tob	acco use contribute to	o the cause of death?
Records,	sicien: The law requir certificate has been si irector, page 2 should I	Completed					24a. Was ar autopsy perform 1 \square Yes 2	prior to death?	utopsy findings available completion of cause of
Vital	ien: Trifical	O	25. Was case referred to medical			26. Place of Death			2010
of V	Physicien: this certific ral director,	To B	examiner? 1 Yes 2 No Hosp	1 Prinpatient 2 ER/Out		# Nursing Hon		nce 6 Other (Spe	cify)
o uc	ding P h. After I funera	:lon:	TEMARDIAN O TONGING	Ba. Date of Injury (Month, Day Year) 28b. T	jury Worl	yat k? Yes 2 □ No	8d. Describe ho	w injury occurred	
Division	or Attending after death. Director: Afte in by the fune	Certification:	Z Nocidoni	Be. Place of Injury - At home, far building, etc. (Specify)			28f. Location (Str City or Town	reet and Number or R , State)	ural Route Number,
_	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical Co	(Check only 2 Medical Examiner:	n: To the best of my knowledge, On the basis of examination and and manner stated.					
	To the within :	Med	29b. Signature and title of/certifier)	1 1 X	29c. License	e number	29	9d. Date signed (Mont	h, Day, Year)
	1		Vote & Floran	in Medical Dor	tor Res	5-00e	05	extenter (72005
	25		30. Name and address of person who completer Regions. The Tel	eted cause of death (Item 23a) (Type, Print)	with Welter	Street	L B. Himos	Maril 21287
	Sta Regist	ate rar	31. Date filed Month, Day, Year) SEP 1 3 200	32. Registrar's Signature	Soules	4 17 1 - 10 - 10	well CCI,	, iny prove	y yard

				eartment of Health and Me	ntal Hygie	2000 29/09
			Decedent's Name (First, Middle, Last)	2.	Date of Death	3. Time of Death
	Physici /Medio		Richard David Miller	S	Month eptember	Day Year 11 P. M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			18 Fort Hoyle Road	Joppa.		Harford
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months Days Hours Min.	Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)
	Director		213-68-1739 49	M	ay 28, 1	
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
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	28a	Director	Maryland Harford Joppa 10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	3a or		18 Fort Hoyle Road	21085		
	n 72 hours after death with the Maryland "natural", or Itams 23a or 28a-f ehow odical Examiner must be notified at	Funeral		Was Decedent of Hispanic Origin? (Specifit Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No-	USA 14. Race - American Indian,
9	after or Ita	Ē	Armed Forces? 1 ☐ Never Married 2 ☑ Married I ☐ Yes 2 ☑ No If Yes, Give		an, etc.)	Black, White, etc.
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21215-0036	be filed within 72 ho ital Hygiene. id othar than "natui evant, Ine Medical	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation 9 kind of work done during most of working	16b	. Kind of Business/Industry
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Z Z	ud 2 sl lith an 27 is r 27 is r			ing Address (Street and Number or Rural R Port Hoyle Road, Jop		
á,	1 al Hea em the		20a Method of Disposition 20b. Place of Disp	osition (Name of Date		Location - City or Town, State
Baltimore,	0 0		1 Burial 2 Cremation 3 Removal from State	matory or other place)		
₫	- 투명근			Memorial Grdhs. 9/1. 2. Name and Address of Facility Mod		
Ba	Departing Department of the service		Dally Wylobook days to	1317 Cokesbury Road		neral Home, P.A.
	- 2		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			Approximate
			shock, or helart fàillure. List only one cause on each line.	00	· + #	Interval Between Onset and Death
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XO	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy		23d. Date of delivery
Э. В	the att	sici	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month Day Year
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of	hys this	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		5 X Residence	6 ☐Other (Specify)
U O	ing F After uner	on	27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	. Describe how in	jury occurred
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Division	at or Attanding P s after death. I Director: After d in by the funera	Certification;	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 28f.	City or Town, Sta	and Number or Rural Route Number, ate)
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	To the Hospitat or Attanwithin 24 hours after deatl To tha Funeral Director: completely filled in by the	Mec	29b. Signature and title of certifier	29c. License number	29d. [Date signed (Month, Day, Year)
}	- s + ö		For and the Use m.	111 2000 101/10		Dep 10 2005
	~~		30. Name and address of person w o piete cause of death (Item 23a) (Type,	DOCO 6 24 C		7- 1- 2000
	8			oppa, Maryland 21085	5	
	Sta	te				
遊	Registr		31. Date filed (Month, Day Year) SEP 1 3 2005	ADDALL!		

State of Maryland / Department of Health and Mental Hygiene 2005 29740 For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician 6:45 Am September 9, 2005 Frances T. Mann /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Silver Spring
If Under 1 Year If Under 24 Hrs. Holy Cross Hospital Montgomery 8. Date of Birth (Month, Day, Year Tan • 17 , 1 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min 1□M 2∰F Days Hours 92 Yrs. 1913 Washington, D.C. Director 214-70-1496 Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or iteme 23a or 28a-1 show any injury or other treumatic event, the Medical Exacting request be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Silver Spring Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2114 Seminary Road 20910 United States Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ White 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dealer Antiques 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Susie Maud Pugh Clinton Roy Tucker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn R. Mann / Daughter 2114 Seminary Road, Silver Spring, Maryland 20910 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cometery, crematory or other place)
Montgomery
Crematorium, Inc. September 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal Irom State 12, 2005 4 □ Donation 5 □ Other (Specify) , ²⁰⁰⁵ Bethesda, Maryland Robert A. Pumphrey Funeral Home Lase, Inc. 7557 Wisconsin Avenue Maryland Funeral Home Bethesda, Maryland 20814-3501 21. Signature of Foreral Service Licensee M01356 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failure Weeks /Medical Due to (or as a consequence of): **Examiner** Pneumonia Weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Atrial Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Anemia of chronic disease 24a. Was an certificate has page 21 No 1 ☐ Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 2 1 🔀 Inpatient 2 ER/Outpatient 3□ DOA After this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D-32332 September 9, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh Gupta, M.D. 9801 Georgia Avenue, Ste. 220, Silver Spring, Maryland 20902 31. Date liled (Month, Day, Year) 32. Registrar's Signature State Registrar

05-6188 B.K.S ANTHONY (

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

HOI	NY G. M	1IL	LER 1 – State Registrar	State of Mary	land / C	Depa <i>Cer</i>	rtment of H	lealth a Death	ınd M	ental Hyg R	iener eg. No.	2005	29741
	Dhuciei		1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month		Year	3. Time of Death
	Physici /Medio		Anthony George 1							SEPT.			2100 P M
	Examir	ner	4a. Facility Name (If not institution, give 11703 Idlewood Ro	street and number) Oad			4b. City, Town, or ROCKVII	Location of LE				ounty of Deat NTGOME	ŔY
	Funeral Director		5. Social Security Number 6. Se 216-64-0720	x 7. Age (In ÑM 2□F	yrs. last birt	thday)_ Yrs.	If Under 1 Year Months Days	Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Sept. 2	reari	Co	hplace (State or Foreign buntry) shington, DC
	yland		10a. State 10b. County	100	c. City, Town	or Loc	ation		····				10d. Inside City Limits
	a-f at	to	Maryland Montgome	ry	Rockv	i 111	e						1 ☐ Yes 2 🎇 No
	death with the Maryland me 23a or 28a-f ahow rithwat be notified at	Director	10e. Street and Number				10f. Zip Code			1	0g. Citize	on of What Co	ountry?
	ath w		11703 Idlewood Ro				20852					d Stat	
	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than enatural; or itame 23a or 28a-1 ahow avant. I'm Madical Examinat must be notified at	by Funeral	11. Marital Status 1 A Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	in U.S.	lf lf	/as Decedent of H Yes, specify Cuba ☐ Yes 2X No	ispanic Orig an, Mexican, Specify:	gin? (Spe , Puerto f	city Yes or No- Rican, etc.)		Black, White Boocify: Wh	
5	72 ho	ted	15. Decedent's Edu (Specify only highest grad		16a.	Deced	ent's Usual Occup	ation	of work in	20	16b. Kind	of Business/	
Z	within 72 ene. than "na:	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			aind of work done of NOT use retired	dining most	OI WOIKII	ig .			
	filed w Hygier other th		17. Father's Name (First, Middle, Last)			Mu	sician	40 14-15-		(Fire Adda)		lusic	
yland	uld be fi dental H rked ot tic avar	Be	Anthony George Mi	llor Ir						(First, Middle, I	waiden Si	umame)	
C.	d 2 should I th and Meni 27 is marke traumatic	2	19a. Informant's Name/Relationship (T		19b	Mailine	Address (Street			Prosise	City or 1	Town State 2	Zin Code)
<u>8</u>	and 2 seath and 2 seath and 27 is		Eugene J. Miller/				Sampson 1				•		
ш	- T = =		20a. Method of Disposition	21	Ob. Place of	Disons	ition /Name of		D	ate		tion - City or	
Ē	Page nt: # ry or		1 ⚠ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	Gate d	of F	atory or other place leaven	1	epte		Silve	er Spr	ing, MD
Baitimor	permit. Pages Depertment of t Important: if its any injury or of once.		21. Signature of Feneral Service Licente	800	100803	Be Be	Name and Addres thesda-Ci thesda,	ss of Facility hevy (Maryla	Robe Chase and	20814-3	Pumph 7557 3501	rey Fu Wisco	neral Home/ onsin Avenue
	Physician /Medical Examiner popularitansit	dical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cord or as a	nsequence of	Of):			+			ular	Approximate Interval Between Onset and Death
O. Box 68	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death		Ectopic pregnancy Other (specify)				230	d. Date of deli Month	ivery Day Year
as, r	luires that n signed by	d by Pr	Part II. Other significant conditions co	ntributing to death but no	t resulting in	the un	derlying cause give	en in Part I.			acco use		the cause of death?
Hecords,	sicien: The faw requires that certificete has been signed b rector, page 2 should be deta	Completed			***********					24a. Was a autops perform	V	24b. Were au prior to death?	topsy findings available completion of cause of
Vital	ctor.	Be	25. Was case referred to medical examiner?					26. Place	of Death	(Check only on			
>	hysic his co	2	11X Yes 2 □ No		2 ER/Out			4 LINUI		ne 5 ☐ Reside		Other (Spec	city) AT SCENE
DIVISION OF	To the Hospital or Atlanding Physician: while 24 hours site death. To the Funaral Director: Atler this certification should be supported by the funeral director.	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Yea		ime of		/ at <br Yes 2 □ N	ło	8d. Describe ho			
2	ital or At urs efter o rat Diraci lled in by		4 Homicide determined	28e. Place of Injury - building, etc. (Si	pecify)					City or Town	, State)		ral Route Number,
	tha Hosp in 24 hou tha Funa ipletely file	Medical	(Check only 27) Medical Exami	sician: To the best of my ner: On the basis of exa and manner stated.	knowledge, mination and	, death d/or inve	estigation, in my of	pinion, death	d place, a h occurre	d at the time, da	ate and pl	ace, and due	to the cause(s)
	To Con	2	29b. Signature and title of certifier Zobium	or Al.				c.M.E		24		signed (Month Γ . 10 ,	
1	yo -		CABILLEAH	ompleted cause of death A U	111 0	PLVIVI.	CADEEL	BALTI	MORE	, MARYLA	ND 21	L201	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's S	Signature	1300							

			For State Registrar	State of Maryland /	Department of Health a Certificate of Death	and Mental Hygier	
	Physici		1. Decedent's Name (First, Middle, La	01010	JR.	2. Date of Death S. Month	Day, Year 3. Time of Death
	/Medic Examin Funeral Director		4a. Facility Name (If not institution gives for the facility Name) (If not institution gives for the facility Number for the f	eneral HOspita	4b. City, Town, or Location of Political Property of Cithday) If Under 1 Year If Under 1 Year Hours Yrs.	of Death	4c. County of Death Accounty of Death Accounty of Death Accounty 9. Birthplace (State or Foreign Country) 96 (Mayland
Y.	the Maryland 28e-f show notified at	ctor	10a. State 10b. County	N/A 10c. City, To	Was explocation that the same of the same	۷	10d. Inside City Limits 1 √ Yes 2 □ No
	n with the	ai Director	10e. Street and Number	verton Heis	10f. Zip Code 2/2/0	10g.	Citizen of What Country?
30N 036	rurs after death with the Maryla et', or items 23a or 28e-f shor Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexican 1 ☐ Yes 2 ☐ No Specify:	gin? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1/6/ 21215-0	should be filed within 72 hours after death with the Maryland of Mental Hyglene. I marked other then "neturel", or items 23a or 28e-f show umatic event, the Medical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired)	of working	Kind of Business/Industry Aaintenance
land	2 should be filed wi and Mental Hygien Is marked other th eumatic event, The	To Be (17. Father's Name (First, Middle, Last	nelson SR	18. Mothe	r's Name (First, Middle, Maio Eta	en Sumame)
Mary	od 2 Ith a 27 is		19a. Informant's Name/Relationship	>M	1b. Mailing Address (Street and Number 2323 Calvertor	11	y or Town, State, Zip Code)
more,	of of or		20a. Method of Disposition 1 Surial 2 Cremation 3 C 4 Donation 5 Other (Speci	20b. Place cemet	of Disposition (Name of ery, crematory or other place)	Date 20c.	Location - City or Town, State
Baltin	permit. Pag Department Importent: I any injury c		21. Signature of Funeral Service lice		22. Name and Address of Facility	1	Lan Pass Bartond, 21229
	Physician		Immediate Cause (Final disease or condition	rplications that caused the death. Do one cause on each line.	o not enter the mode of dying, such as a Infarction	cardiac or respiratory arrest,	Approximate Interval Between Onset and Death
8760,	Medical Examine physician and the purial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Early carrying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to for as a consequence c. Due to for as a consequence d.	nodeficiency	ve Virus	
P.O. Box 68	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death 9 □ Unknown	h 3 □Ectopic pregnancy 5 □ Other (specify)	_	23d. Date of delivery Month Day Year
ds, P	uires that i signed b id be deta	by P	Part II. Other significant conditions	contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacc 1 ☐ Yes	o use contribute to the cause of death? 2 No 3 Probably 4 Munknown
Division of Vital Records,	: The law require cate has been si page 2 should t	Completed				24a. Was an autopsy performed 1 Yes 2 120	
of Vita	Physicien: this certific al director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☑ Inpatient 2 ☐ ER/O	outpatient 3 DOA Other: 4 Nu	of Death (Check only one) rsing Home 5 ☐ Residence	6 □Other (Specify)
sion o	tending Phy Jeath. tor: After thi the funeral	ertification;	27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) in	Time of Injury at Work? M 1 Yes 2 1	28d. Describe how in	jury occurred
Divis	tel or Att rs after de el Direct	O	3 ☐ Suicide 6 ☐ Could not be determined		arm, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospitel or within 24 hours afte To the Funerel Dircompletely filled in	edical	(Check only 2 Medical Example)	hysician: To the best of my knowledg miner: On the basis of examination a and manner stated.	ge, death occurred at the time, date and nd/or investigation, in my opinion, deat	d place, and due to the cause h occurred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
	Tot withi Tot com	Σ	29b. Signatule and title of certifier	Dondy	29c. License number	9535 Se	Pate signed (Month, Day, Year) Plambor 11, 2005
	2		Koti Owusu	completed cause of death (Item 23a)	(Type, Brint)	al Hospite	a/
	Sta Registr		31. Date filed (Month, Day, Year) CED 1 3 201	32. Registrar's Signature	Sparke	1	

State of Maryland / Department of Health and Mental Hygiene 2005 29743 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Dolores Joan Napp September 07,2005 2:05 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Arden Courts Assisted Living Pikesville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Market Pays Hours Min. (Month, Day, Year) Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)

September 05,1929 Pennsylvania 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 10 M 2 T F Yrs. Director 206-22-8503 76 Usual Residence of Decedent with the Maryland 10a State 10b. Count 10c. City, Town or Location 10d, Inside City Limits or 28a-f ehow r than "natural", or iteme 23a or 28a-f ehov the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director MD Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7103 Deerfield Road 21208 United States of America death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) e filed within 72 hours after on Hygiene.
other than "natural", or iter 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0 12 Retired Tax Filer Finance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any july or other traumatic event once. Be Vincent Bonacci Ida Spenella ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Spouse) 7103 Deerfield Road, Pikesville, Maryland 21208 John L. Napp 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Comfort Crematory 09/09/05 Alexandria, Virginia ^ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loring Byers Funeral Directors 21. Signature J Funeral Service Licensee 8728 Liberty Road, Randallstown, Maryland 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 5+09 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any cause. Enter Underlying Cause (Disease or injury Due to for as a consumence of Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) the the 9 Unknown 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2 X No 1 Tes 2.2 No 1 TYes : After this certification and transfer the state of the the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ARDEN COURTS Other: ၉ 1 🗌 Yes 2. No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) } LIVING 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Š 4 Homicide 29a. Certifier 1 or certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mes 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) oad WD3,603 MUMMIL 31. Date filed (Month, Day, Year) 32. Regis#ar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistrar Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 10:50P M C. OFFIT SEPT. 2005 HARRYETTE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 11 SLADE AVENUE APT. #203 PIKESVILLE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Yea 12/08/1937 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□M 2XF Hours Months Days Min. 212-36-7770 67 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or itams 23a or 28a-1 ahow traumatic event, the Modical Examiliar must be notified at MD BALTIMORE PIKESVILLE 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 11 SLADE AVENUE APT. #203 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No WHITE Baltimore, Maryland 21215-0036 Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TEACHER BALTIMORE CITY SCHOOLS permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 is marked othe any injury or other traumatic event, since. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be CAPLAN HOWARD BEATRICE GOLDMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAUL B. OFFIT / HUSBAND 11 SLADE AVENUE APT. #203-PIKESVILLE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State BETH EL MEMORIAL PARK 09/11/2005 RANDALLSTOWN, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee wit 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Lung Cancer Immediate Cause (Final Physician 6 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, backing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Sua to for as a nonscollance off: Examiner use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 2**X** No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No ٥ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 XNatural 2 Accident Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a partifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check of one) and manner stated within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and ti Sept. 08 2005 D0055065 person who completed cause of death (Item 23a) (Type, Print) Martin J. Edelman, M.D. 10 Greenebaum Cancer Center, 22 S. Greene St N9E08 Baltimore MD 21201 31. Date filed (Month, Day, Year) State SEP 1 3 2005 Registrar

State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Petrlik Α. 9:21 PM Sept. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard County General Hospital Columbia Howard If Under 24 Hrs. 8. Date of Birth (Month, Day April 20 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Min. 1 ☐ M 21X F 86 220-05-7761 Yrs. Director ,1919 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or items 23e or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Columbia Howard Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5400 Vantage Point Road 21044-2681 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, filed within 72 hours after 1 □Yes 2 □ No If Yes, Give 1 → Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: ρ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) machine accountant permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, IL. n 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Theresa Sima Frank Petrlik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 302 Broadmoor Road, Baltimore, Maryland 21212 Richard Carey - nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Bayview Crematory 9/12/2005 Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Hubbard Funeral Home, Inc. once. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician rneumonia 1 week /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 physician Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. I the as been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 3 Probably 4 Wunknown 1 Tyes 2 No. Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy tal or Attending Physician: The safter death.

Is after death.

In Director: After this certificate of in by the funeral director, pa 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2. No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number eted cause of death (Item 23a) (Type, Print)

11055 Little Potument Pkmy Columbia MD 21044 30 Name and address 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygien 2005 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** September 1, 2005 Price B:00P Benjamin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Saint Joseph Medical Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 ☐ F Yrs. Maryland 91 23, Director 215-09-3011 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland Queen Ann's Crumpton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or items 23a or P.O.Box 329 115 Second Street 21628 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify 3XXWidowed 4 □ Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ent: if item 27 is marked other than ury or other traumatic event, the MS Elementary/Secondary (0-12) College (1-4or 5+) Package Goods 0wner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Corinne Ryland Harry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Nancy Price Clerkin 10 Felton Road Lutherville, Maryland Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. 4 Donation Hilltop Service Corp. 9-13-2005 Towson Maryland 21. Sign up of Ture a Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a CONGESTIVE HEART FAILURE SECONDARY /Medical Due to (or as a consequence of): **Examiner** SEVERE CARDIOMYOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. attending physician Completed by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Year Month Dav 4 Pregnant at time of death 5 Other (specify) P. 0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other. 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🐼 No 1 N Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 T Homicide within 24 hours a

To the Funerel C

completely filled 154 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number m-cala m.o September 11 D41410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 1 3 2005 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 State Registrar

Physicia	an	1. Decedent's Name (First, Middle,	State of Mary 1 per phy Ge		Sr.		2. Date of D Month	eath Da		Year	3. Time of Death
/Medic		JOHNNY	L. PLA	FEO			09	03		05	7:27p M
Examin	er	4a. Facility Name (If not institution,			Baltim	or Location of Death		40	. County	of Death	
	М	Bon Secours F 5. Social Security Number		yrs. last birthda			8. Date of B	irth		9. Birthp	lace (State or Foreign try)
uneral irector		131-32-6893 Usual Residence of Decedent	¹¼ ^{M 2□} F 6]		Months Days		(Month, D	ay, Year)	44	N S	try) \
Hygiene. nther then "naturel", or items 23e or 28e-1 show ent, the Medical Evantiner must be notified at		10a. State 10b. County	100	c. City, Town or	Location					1	0d. Inside City Limits
rthen "naturel", or items 23e or 28e-f show the Medical Espathaet must be notified at	tor	MD NA	A E	Baltimo	ore						1 X X es 2 □ No
9 10	ire	10e. Street and Number			10f. Zip Code					/hat Coun	try?
	rai	209 South Mot			1	1223			U.S.		
	nue	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13	 Was Decedent of I If Yes, specify Cub 	Hispanic Origin? (Sp ean, Mexican, Puerto	ecify Yes or N Rican, etc.)	0-		k, White,	an Indian, etc.
	d by Funeral Director	1 Never Married 2 Marrie 3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes XXNo				Specify	בים	ack
	Be Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Dec	cedent's Usual Occu ve kind of work done	pation during most of work ed)	ring	16b. K	(ind of Bu	siness/Ind	dustry
	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		Fruck Dr			Mod	042	10 0	ompany
	Ö	12th grade 17. Father's Name (First, Middle, L			ILUON DI	18. Mother's Nam	e (First, Middl				Omparry
	To B	Robert Plateo				Anna B	ell Ba	ttl	e		
	-	19a. Informant's Name/Relationsh	ip (Type, Print)			t and Number or Ru					
		Kimberly L. R	eed-Daughter				reet,				Md 21223
		20a. Method of Disposition	3 □ Removal from State	Ob. Place of Dis cemetery, ci	position (Name of rematory or other pla	ice)	Date	20c. L	ocation -	City or To	own, State
		Burial 2 Cremation 4 Donation 5 Other (Sp	ecify)		Zion		3/05_	Ва	ltin	nore	, Md
		21. Someture of Funeral Service L	icense		22. Name and Addr March F/						
once.		yokn N	Jahne	J She I	4300 Wab	ash Ave	Balt	imo	re,	Md	21215 Approximate
		23a. Part1. Enter the disease, or of sheck, or heart failure. List of	inly one cause on each line.	A 1 O	niter the mode or dy	ing, such as cardiac	or respiratory	arrest,			Interval Between Onset and Death
al		Immediate Cause (Final disease or condition resulting in death)	a	7(1)							
er			Due to (or as a co	nsequence of):							
ı	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	nsequence of):	20					_	
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c	IVDI	7						
	Exa	resulting in death) Last	Due to (or as a co	nsequence of):							
	edicai		d								
	Med	IF FEMALE:									
	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr	Fetal death	B Ectopic pregnand	су			23d. Dat Mor	e of delive ath	ery Day Year
	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time 9☐Unknown	or death :	Other (specify)						
		Part II. Other significant condition	ns contributing to death but no	ot resulting in the	underlying cause gi	iven in Part I.	23e. Dio	tobacco	use contr	ribute to th	ne cause of death?
	d by	Kenn	1 FMla	re			1 🗆	Yes 2	!□No	3 Prob	ably 4 Unknown
	ompleted	Jaco	n Decili,	h.			24a. We		24b. V	Vere auto	psy findings available impletion of cause of
l	mo	0		1 -			per 1 Yes	opsy formed? 2 3	0	leath?	
	C	25. Was case referred to medical				26. Place of Dea		/			
	000	examiner?	Hospital: Inpatient	2 ER/Outpat	ient 3 DOA Ot	ther: 4 Nursing H	ome 5 Re	sidence	6 Othe	er (Specif	y)
	0 0	1 Yes 2 No	y							ed	
	To B	27. Manner of Death	28a. ate of Injury			ury at ork?	28d. Describe	how inju	ity occurr		
	To B	27. Manner of Death 1 Natural 5 Pending 2 Accident investig	28a. ate of Injury (Month, Day Ye	28b. Time ar) Injun	of 28c. Inju]Yes 2□No					
	To B	27. Manner of Death 1 Deatural 5 Pending	28a. ate of Injury (Month, Day Ye	28b. Time ar) Injun	of 28c. Inju]Yes 2□No	28f. Location		nd Numb	er or Rura	d Route Number,
	Certification; To B	27. Manner of Death 1	28a. ate of Injury (Month, Day Ye ation of be ned 28e. Place of Injury building, etc. (S	ar) 28b. Time Injury At home, farm, Specify)	of 28c. Injuy With M 1 C	Yes 2 □No	28f. Location City or T	(Street a. own, Stat	nd Numbi		
	Certification; To B	27. Manner of Death 1	28a. ate of Injury (Month, Day Ye (Month, Day Ye ened) 28e. Place of Injury building, etc. (S) 3 Physician: To the best of m. (xaminer: On the basis of examiner:	At home, farm, Specify) y knowledge, de amination and/or	of 28c. Injuy M 1 [street, factory, office	Yes 2 No	28f. Location City or T	(Street a own, Stat	nd Number	nner as si	tated.
	ertification; To B	27. Manner of Death 1	28a. ate of Injury (Month, Day Ye ation of be hed 28e. Place of Injury building, etc. (S	At home, farm, Specify) y knowledge, de amination and/or	of 28c. Injuy WC M 1 [street, factory, office at the tinvestigation, in my	Yes 2 No	28f. Location City or T	(Street a own, Stat e cause(s a, date an	nd Numbee) s) and mad place, a	nner as si and due to	tated.
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Completely med in by the langual director	edical Certification: To B	27. Manner of Death 1	28a. ate of Injury (Month, Day Ye (Month, Day Ye building, etc. (So physician: To the best of manufacture).	At home, farm, specify) y knowledge, deamination and/or	street, factory, office ath occurred at the tinvestigation, in my 29c. Licen	time, date and place opinion, death occurse number	28f. Location City or T	(Street a. own, State e cause(s. o., date an 29d. Da	nd Number e) s) and ma d place, a ate signed	nner as si and due to	ated. the cause(s)
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4	Medical Certification; To B	27. Manner of Death 1	28a. ate of Injury (Month, Day Ye building, etc. (S) 3 Physician: To the best of mexaminer: On the basis of examiner stated.	At home, farm, pecify) y knowledge, deamination and/or	street, factory, office ath occurred at the tinvestigation, in my 29c. Licen	time, date and place opinion, death occurse number	28f. Location City or T	(Street a. own, State e cause(s. o., date an 29d. Da	nd Number e) s) and ma d place, a ate signed	nner as si and due to	ated. the cause(s)

		_	1- For State of Maryland /	Department of He	ealth and Mental Hyg	iene 2005 29748
	Physicia	an	1. Decedent's Name (First, Middle, Last)	billing	2. Date of Deal Month	Day Year
	/Medic Examin	al -	4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or	Location of Deeth al Timere	4c. County of Death n/a
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 80 Usual Residence of Decedent	oirthdey) If Under 1 Year Months Days	If Under 24 Hrs. 8. Date of Birth (Month, Dey. Aug. 10)	yeer) 9. Birthplace (State or Foreign Country) 1925 Maryland
	Maryland -f show	tor	10a. State 10b. County 10c. City, To	wn or Location		10d. Inside City Limits 1 ☐ Yes 2 ☐ No XX
	with the	Funeral Director	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Country? USA
	death v ms 23a	neral	2814 Louisiana Ave. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	21227	spanic Origin? (Specify Yes or No- n, Mexican, Puerto Rican, etc.)	14. Race - American Indian,
900	ours after ral', or Ite	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 22 ☐ No If Yes, Give Year or Dates:	1 □ Yes 2√CXNo	Specify: white	Black, White, etc. Specify: white
21215-0036	within 72 hours after death with the Maryland ene. Than "natural", or frems 28a or 28a-f show ha Medical Esarchier must be notified at	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	a. Decedent's Usual Occupa (Give kind of work done di life. DO NOT use retired) omemaker	urina most of workina	16b. Kind of Business/Industry Home
	il Hygie other i	Be Co	8th Ho		18. Mother's Name (First, Middle,	Maiden Sumame)
Maryland	should be and Mental marked o	To E	Wilson Lee Hoffman		Dora Irene Peter	
Mar	nd 2 sh lith and 27 is n r traun		D 1 1 7 D1 1111 C		Ave. Baltimore,	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 53a or 28a-f show any righty or other traumatic event, the Medical Exacting must be notified at ance.		20a. Method of Disposition 1	of Disposition (Name of tery, crematory or other place ore crematory n oark	Date Sep. 8, 05 B	20c. Location - City or Town, State Altimore City
Balti	permit. Pa Departmer Important: any injury pnce.		21. Signature of Fyrieral Service Licentee	3620 Wilke		e, Maryland 21229
1	Physician		23a Ran Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a.	o not enter the mode of dying	g, such as cardiac or respiratory arr	est, Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence	ctrolyte	disturban	nce I week
V	and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events	e of):	etinfect	ion (week
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68	tificate ng phys as the		d			
P.O. Box	The law requires that the death certificate be exate has been signed by the attending physician page 2 should be detached for use as the burian	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death 9 □ Unknown	th 3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
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Division of Vital Records,	The law reate has bee	Completed by	Diabetes mellitus		24a. Was a autops perfor	sy prior to completion of cause of
Vita	ysician: The la is certificate ha director, page 3	Be	25. Was case referred to medical examiner?	Othe	26. Place of Death (Check only or	
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Divisi	al or Attendi after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (S City or Town	treet and Number or Rural Route Number, n, State)
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled 2 Medical Exeminer: On the basis of examination and manner stated.	ge, death occurred at the tim and/or investigation, in my or	ne, date and place, and due to the c pinion, death occurred at the time, d	ause(s) and manner as stated. late and place, and due to the cause(s)
	To the within To the comp	W	29b. Signature and title of certifier MD MD	29c. License	number 391 8	eptember 6, 2005
	8		30. Name and address of person who completed cause of death (Item 23a MIN 9 1 3 3 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	enue. (Si	altimore A	Naryland 21227
	St: Regist		SEP 1 3 2005	to forthe		

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	Dhusisi		1. Decedent's Name (First, Middle, Last)			2	. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Dori	s Jean Post P			eptembe		
	Examir		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, o	or Location of Death		4c. County of Dea	th
		•	Montgomery Hos			Rockville			gomery
	Funeral		5. Social Security Number 6. Sec	TM 200 F	last birthday) If Under 1 Year Yrs. Months Days		Date of Birth (Month, Day,)		thplace (State or Foreign buntry)
	Director		233-48-3914 Usual Residence of Decedent	76	110.	l N	ovember 5	, 1928 We	st Virginia
	and		10a. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits
	Mary feho	ō	Maryland Monts	gomery		Bethesda			1 ☐ Yes 2 📉 No
	the 288	Director	10e. Street and Number	zonier y	10f. Zip Code	Bethesda	100	g. Citizen of What Co	ountry?
	3a or		4801 Ham	npden Lane #40)1	20814		United	l States
	death ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?		Hispanic Origin? (Speci pan, Mexican, Puerto Ri	fy Yes or No-	14. Race - Ame Black, Whit	erican Indian,
9	after or Ite	교	1 ☐ Never Married 2 X Married	1 ☐ Yes 2 X No If Yes, Give	1 ☐ Yes 2 ☒ No		oa. 1, 010.,	Specify:	9, 010.
93	hours after death with the Maryland tural', or Items 23a or 28a-f show Exercities found be retilized at	d by	3 Widowed 4 Divorced	Year or Dates:					White
21215-0036	72 nai	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT user reje	pation during most of working	16	6b. Kind of Business	/Industry
12	within iene.	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	Computer Yro g	ramer Proj	ect	Cmi+h	sonian
2	O 0 0 -		17. Father's Name (First, Middle, Last)	4	Maii	ager 18. Mother's Name (First, Middle, Ma		SUITAII
and	be d la la la la la la la la la la la la la) Be		estes Post			Clara E	rcle Strad	for
Maryland	2 should the and Ment is marked aumatic	٦	19a. Informant's Name/Relationship (T)		19b. Mailing Address (Street				
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Benjamin Benjamin F. Poins		4801 Hampde	en Lane #40	1 Bethe	sda. Marvl	land 20814
Je,	is 1 and 2 of Health a item 27 is other trai		20a. Method of Disposition	20b. P	Place of Disposition (Name of permetery, crematory or other place	Dar	te 20	0c. Location - City or	Town, State
9	Page: ent o nt: If		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	Heavner Cemete	rv Septe	2005	Buckh West V	irginia
Baltimore,	permit. Pages 'Department of H Important: If ite any injury or of		21. Signature of Fundral Service Licens		22 Name and Addre	ass of Eacility Robe	rt A Pi	umphrey Fi	meral Home/
Ö	Depa Impo any ic			MO03					onsin Avenue
			23a. Part1. Enter the disease, or composition of the shock, or heart failure. List only o	ications that caused the deat ne cause on each line.	h. Do not enter the mode of dy	ing, such as cardiac or	respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Advanced Co	olon Cancer				Onset and Death Months
	/Medical		resulting in death)	Due to (or as a conseq					
	Examiner	_		b					
	sit ad	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence or):				
	and erran	xam		c Due to (or as a conseq	uence of):				
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State of Maryland / Department of Health and Mental Hygiene 2005 1 - For State Registre 29750 Certificate of Death Reg. No. 2. Date of Death Physician 7:10 AM uster 8105 /Medical Name (If not institution) give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hospice 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 246-40-7300 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show is marked other than "natural", or items 23a or 28a-f show aumatic event, the Madical Examiner must be notified at 1 Yes 2 No Funeral Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? venue 21207 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married Baltimore, Maryland 21215-0036 1 Yes 25 No Specify Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working fe. DO NOT use whire() College (1-4or 5+) Elementan / econdary (0-12) permit. Pages 1 and 2 should be filler.
Department of Health and Mental Hygh Important: If Item 27 is marked any injury or other 1-1. Be Burial 2 Cremation 3 F Donation 5 Other (Specify) 2 Cremation 3 Removal from State 21. Signature of Funeful Service License 23a. Part 1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** wecks /Medical Due to (or as a consequence of): Examiner Lumoria Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 1 Jetics Die to (or as a consequence of). attending physicien and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death Month Day Year signed by the at d be detached for 5 Other (specify) of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 □Unknown certificate has been s irector, page 2 should 1 🗌 Yes 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 22 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 № No 1 🗌 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSPICE 2 ER/Outpatient 3□ DOA 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 58303 September 8 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Agran 1001 42 ranson mo Charles N. heres 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 1 3 2005 Registrar

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Gresin

				1- State of Maryland / Department of Health and I Certificate of Death		giene 2005	29751
	2	Physici	an	1. Decedent's Name (First, Middle, Last) Harriett L. Rogers	2. Date of Dea Month	ath Day Year	3. Time of Death
	The second	/Medic	al	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	Septem	4c. County of Dea	
		Exami		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.		N/A	the least Chate on Familia
	*	Funeral Director	979	5. Social Security Number 6. Sex 1	(Month, Da	0,1947 Ma	thplace (State or Foreign buntry)
165		Maryland	tor	10a. State Margland 10b. County N/A 10c. City, Town or Location Baltimore			10d. Inside City Limits 1 XYes 2 □ No
200		h with the	Funeral Director	100. Street and Number 1102 North Milton Avenue 21205		10g. Citizen of What Co United St	ountry?
pricely	980	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If Item 27 is marked other then "netural", or Items 23s or 28s-f ehow or other traumatic event, the Mudical Exactions from the rediffied at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Puert If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (S	Specify Yes or No to Rican, etc.)	14. Race - Am Black, Whi	
1948	21215-0036	within 72 ho ane. then "netur	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work from Elementary/Secondary (0-12) Coflege (1-4or 5+) House Keeping	rking	Domesti	
511		ould be filed withi Mental Hygiene. arked other ther atic event, I'le M	Be		me (First, Middle,	Maiden Sumame)	
mous	Maryland	nd 2 should be alth and Mental 27 is marked (rr traumatic ev	၉	19a. Informant's Name/Relationship (Type, Print) Marian L. Chase - Sister 4709 Dunkirk Avenue	ural Route Numbe	er, City or Town, State,	zip code) y land 21229
K	Baltimore,	Pages 1 and 3 nent of Health int: If Item 27 iry or other tr		20a. Method of Disposition 1 Burial 2 (Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Bay View Crematory, Inc.			, Maryland
	Balti	permit. Pages Department of I important: If its eny injury or o once.		21. Sign Mare of Funeral Service Licensee 22. Name and Address of Faquity Calvin L. Williams P.O. Box 11651	Funero altimor	1 Service, 1 e, Marylan	d 21229
4		Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a Palmana, Education Education Education)	c or respiratory a	rrest,	Approximate Interval Between Onset and Death
		/Medical Examiner		resulting in death) Due to (or as a consequence of):			
		n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that mittated events Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): C.			
		ificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C			
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	Division of Vital Records, P.O.	el or Attending Phy s after death. Il Director: After this id in by the funeral c	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tox	Street and Number or R wn, State)	ural Route Number,
		To the Hospitel or within 24 hours after To the Funeral Director completely filled in b	cal	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place 3 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place 3 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place 3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 3 Medical Examiner: On the basis of examiner and a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and the control of the basis of examiner and the control of the basis of examiner and the control of the basis of examiner and the control of the basis of examiner and the control of the basis of examiner and the control of the basis of examiner and the control of the basis of examiner and the control of the basis of examiner and the control of the basis of examiner and the basis of examiner and the basis of examiner and the basis of examiner and the basis of examiner and the basis of examiner and the basis of examiner and the basis of examiner and the basis of examiner and the basis of examiner and the basis of examiner and the basis of examiner and the basis of examiner and the basis of examiner and the basis of examiner and the basis of examiner and the basis of examiner and the basis of examiner and the basis of exami	urred at the time,	date and place, and du	e to the cause(s)
		To the within To the comp	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mon	th, Day, Year)
		59		30. Name and address of person who completed cause of death (frem 23a) (Type Print)		September 1	2005
		7		Chad Hausen, 2401 W. Belvedere, Baltimo	re MA	21215	
		Sta Regist	ate rar	29b. Signature and title of certifier 29c. License number			

			ricase				nt of Hoolth and			
			For State Registrar	State of Ma	aryland /	Certifica	ent of Health and ate of Death		eg. No. 200!	5 29752
	0.		Decedent's Name (First, Middle, La	st)				2. Date of Dea	th	3. Time of Death
	Physici /Medic		Geraldine.	Rose	Kro	daely		Sept.	Day Yeer	
	Examin		4a. Facility Name (If not institution, give	a street and number)	1.1	4bl Ci	y, Town, or Location of Dea	ith	4c. County of De	ath
			Arden Court	Vursing	Hon		ALTMORE			
	Funeral Director		5. Social Security Number 6. S	M 200 F	e (In yrs. last	Yrs. Month	der 1 Year If Under 24 Hr s Days Hours Mir			inthplace (State or Foreign Country)
			Usual Residence of Decedent		00			1-//-	79. 177	ARYLAND
	urylan show	ъ.	10a. State 10b. County		10c. City, To	own or Location	17.			10d. Inside City Limits
	Ba-f outlie	ecto		MORE	<u> </u>	PARK				1 ☐ Yes 2 ☐ Mo
	with t	Funeral Director	10e. Street and Number	ah Ral		107.	Zip Code		log. Citizen of What C	L Country?
	ns 23	era	11. Marital Status	2. Was Decedent	Ever in U.S.	13. Was Dec	cedent of Hispanic Origin? (becify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Arr	
9	or Ite	Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give	No		pecify Cuban, Mexican, Pue	rto Rican, etc.)	Black, Wh	ite, etc.
9	illed within 72 hours after death with the Maryland Hyglene. wher then "naturel", or Items 23a or 28a-f ehow ent, the Medical Examinat must be motified at	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:					Specify: U)1)17C
Ϋ́ L	"nati	Completed	15. Decedent's E (Specify only highest gr	Jucation ide completed)	1	6a. Decedent's U: (Give kind of the life. DO NO1	sual Occupation work done during most of w "use retired)	orking	16b. Kind of Busines	s/Industry
72	filed withi Hygiene. other then	шо	Elementary/Secondary (0-12)	College (1-4or !	5+) /	MISSI			City of	BAITIMOR
פ	e filed Il Hyg othe vent.	BeC	17. Father's Name (First, Middle, Last)		9	18. Mother's N	ame (First, Middle,	Maiden Sumame)	10110177100
<u>Jar</u>	2 should be and Mental le marked c	ToE	John Del	azio			Lina	Pitre	11.	
Maryland 21215-0036	2 sho		19a. Informant's Name/Relationship	Type, Print)	1	9b. Mailing Addre	ss (Street and Number or I	Rural Route Numbe	, City or Town, State,	Zip Code)
	1 and 3 Health tem 27		20a. Method of Disposition	ey	20b. Place	of Disposition (A	athermill M	Date	20c. Location - City o	21236 or Town, State
nor	Pages nent of ant: If it ary or o		1 Bunal 2 Cremation 3 C 4 Donation 5 Other (Speci		ceme	etery, crematory o	r other place)	15-1cm	PAIT MA	n= 1110
Baltimore,			21. Signature of Funeral Service Lice	·	More	22. Name	and Address of Facility	ALTI MOR	E mn 2	1234
ñ	permit. Departr Importe any inji		Kindolula	-Zawnot	nu	FUTUS	The state of the s	and the second second	WHARFOR	Comment Technical
	100		23a. Part 1. Enter the disease, or con shock, or heart failure. List only	plical as that caused one cause on each li	d the leath. D	Do not enter the m				Approximate Interval Between
	Physician		Immediate Cause (Fical disease or condition	Jenile	Deni	ulia 1	1/2 heims	Type		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequen	ce of):	U	0		
		7	Sequentially list conditions,	b. Due to for as	à consequen	ce of:				
	uted s insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			,-				
oʻ	te be executed ysician and te burial-transit		that initiated events resulting in death) Last	Due to (or as	a consequen	ce of):				
3760	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Ical		_ d						
89 x	entifica ling ph e as t	Physician/Med	IF FEMALE:	00-14						
Вох	attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth 4□Pregnant a	2 Fetal de	ath 3 □Ectopic			23d. Date of de Month	elivery Day Year
o.	y the d	ysic	1 ☐ Yes 2 🗹 No 9 ☐ Unknown	9□ Unknown	t time of deati	1 5 Other	specily)			
Δ.	The law requires that the death certifica the has been signed by the attending phoage 2 should be detached for use as it.	by Pr	Part II. Other significant conditions	contributing to death t	out not resultin	g in the underlying	g cause given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
Records,	w require been sig should b	ed t	Physortensia	n				1 🗆 Y	es 2 No 3□F	robably 4 Unknown
900	ław requ as been 2 shoulk	plet	O Alnal	Bullal	M			24a. Was a		autopsy findings available completion of cause of
		Completed	haseles "	nell ilms)			perfor	med? death?	
v ita	Physician: r this ertificatal director, i	Be	25. Was case referred to medical examiner?	Hospital:			Other	eath (Check only or	, /	Associal -
o	Physical distribution	To t	1 Tyes 2 No 27. Manper of Death	28a. Date of Inju		b. Time of	28c. Injury at	Home 5 ☐ Resid	ence 6 Other (Sp.	ecity) Lung
ion	Attending Ph ir death. ector: After th by the funeral	atlor	1 Natural 5 Pending 2 Accident investigation	(Month, Da	ıy Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No			U
Division of	e 0 11	Certification;	3 ☐ Suicide 6 ☐ Could not to determined	289. Place of in	jury - At home tc. (Specify)	, farm, street, fact	ory, office	28f. Location (S City or Tow	treet and Number or F	Rural Route Number,
	itel or ral Di lled in		7					1		
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis o and manner st	of examination	dge, death occurr and/or investigati	ed at the time, date and place on, in my opinion, death oc	ce, and due to the courred at the time, o	ause(s) and manner a ate and place, and du	as stated. ue to the cause(s)
	o the	Mec	29b. Signature and title of certifier	and mariner st	AQ	2	29c. License number		9d. Date signed (Mor	nth, Day, Year)
)	7		> /www	any"			D3043	3 \	eft 12",	2005
	10 0		30. Name and address of person who	completed cause of	death (Item 23	a) (Type, Print)	HARLET ST	SHII	HARLE M	10 21204
	Sta	oto	31. Date filed (Month, Day, Year)	32 Regist	rar's Signature		MINIOUCJ JI	וונוני	7000	17 2109
**	Regist		SEP 1 3 2		. K	Boasta	9			

State of Maryland / Department of Health and Mental Hygiene 2005 29753

		-	State Amend Item4a-c Registrar 1. Decedent's Name (First, Middle, Last)	&Unpend Ite	m 23ag2	tincete of	Seathe G	349 11-22 tas	1_05	00 20100
			Decedent's Name (First, Middle, Last)					2. Date of De	ath Day	3. Time of Death
	Physicia /Medic		Adriana		Richa	rds		Septem	per 11,	2005 6:53 а.м
	Examin	er	4a. Facility Name (If not institution, give str 6902 - Homeway Johns	Hopkins Bay	view	4b. City, Town, or Dundalk	Baltimo	ore City	Balt:	of Death
	Funeral Director		5. Social Security Number 6. Sex 1 1 1	7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year Months Days 1 23	If Under 24 Hr. Hours Mir	. (Month, Da	y, Year) 9, 2005	Birthplace (State or Foreign Country) MD.
	put 🛊		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation			•	10d. Inside City Limits
	e Maryla	Director	MD Baltimore		Dundalk	ζ				1 ☐ Yes 2 XNo
	th with the 23a or 2		6902 Homeway			10f. Zip Code 21.	222		10g. Citizen of US	SA
980	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or Items 23s or 28s-f show aumatic event, the Madical Executiver must be notified at	by Funeral	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	 Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	ispanic Origin? (in, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)		ce - American Indian, ick, White, etc. ^{fy:} White
Maryland 21215-0036	within 72 ho ene. then "natur he Madical I	Completed	15. Decedent's Educa (Specify only highest grade	ation completed) College (1-4or 5+)	(Give	dent's Usual Occupi kind of work done o DO NOT use retired	during most of w	orking	16b. Kind of B	Business/Industry
land 2	ould be filed v Mental Hygie varked other t	To Be Co	N/A 17. Father's Name (First, Middle, Last) Hobert Richards		, I	VA		campones	Maiden Sumar	пе)
	s 1 and 2 should if Health and Mer item 27 te marke other traumatic		19a. Informant's Name/Relationship (Type Gina Camponeschi	mother		ng Address (Street a				, State, Zip Code)
Baltimore,	Pages 1 and of Herent of Herent of Herent of Herent III is the mury or other		20a. Method of Disposition 1 ☐ Burial 2 【▼Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State		esition (Name of matory or other place Crematory		ember 2005	20c. Location Baltimo	- City or Town, State
Balti	permit. Pages 1 Depertment of H Important: If ite eny injury or ott		21. Signature of Funeral Service Licensee		20	Name and Address 7110 Soll	Funeral ers Poir	Home Of	Dundalk Dundalk	x,P.A. x,MD. 21222
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the discause on each line.						Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Methadone I		tion			<u> </u>	Onset and Death
	Examiner	ner	Sequentially list conditions, tary, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to Jor as a con-	suquence of):					
o,	ficate be executed physicien and is the burial-transit	Examin	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a con-	sequence of):					
68760,	ate be thysici the bu	Medical	d.							
.O. Box 6	The law requires that the deeth certificate be executed site has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time 9 Unknown	etal death 3	Ectopic pregnancy Other (specify)	,			ate of delivery onth Day Year
<u>α</u>	quires that I n signed by uld be deta	۵	Part II. Other significant conditions cont	ributing to death but not	resulting in the u	inderlying cause giv	en in Part I.		obacco use con Yes 25 No	ntribute to the cause of death? 3 Probably 4 Unknown
I Records,		Completed						24a. Was auto perfo 1⊠ Yes	psy ormed?	Were autopsy findings available prior to completion of cause of death? V☐ Yes 2☐ No
Vital	Physicien: 1 this certificel ral director, p	Be	25. Was case referred to medical examiner?	ospital:		O#b		eath (Check only	one)	
to	9 v =	1	12 Yes 2 No 27. Manner of Death	28a Date of Injury	28b Time o		4 Nutsing	Home 5 ☐ Res	dence 6 Ott	
on	ding Afte fune	tlon	1 □Natural 5 □ Pending 2 □ Accident investigation	Found 9-11-05	Found	Wor	k? Yes 2∭XNo			methadone
Division	I or Attending after death. Director: Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - A building, etc. (Sp Found at h	ecify)	reet, factory, office		28f Location /	Street and Num wn, State) 69	ober or Rural Route Number, O2 Homeway
)	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C		cian: To the best of my	knowledge, deat			ce, and due to the	cause(s) and m	nanner as stated. , and due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier FC 34 1e	end MI)	29c. Licens	ocme		29d. Date sign Septemb	ed (Month Day, Year) ber 12, 2005
•	000		30. Name and address of pirson who con Tasha Z Green			Print) 111 Pe	enn Stre	et Balt	imore, 1	Maryland 21201
	St. Regist	ate rar	31. Date filed Honts, Pay, Year) 2005	. (Registrar's S	ignature	M.				

State of Maryland / Department of Health and Mental Hygien 2005 29754 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Kodgers Bessie 6:30 a.M 08 27 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3818 Janbrook Road Randallstown Balto If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2**X**) F 2110-20-4446 Director 87 Yrs 1-27-1918 Vа Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examination intestice notified at 10d. Inside City Limits Director 1 ☐ Yes 2 X No Md Baltimore Randallstown 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 3818 Janbrook Road USA 21133 death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours efter of Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iter any Injury or other traumetic event, the Mudical Exarta ear Ance. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6th grade N/A Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William H. Webb Lillie Giddius 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bessie S. Black -Daughter 5531 Cadillac Avenue Balto, Md 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet 9-6-2005 Owings Mills, Md * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lic 22. Name and Address of Facility March F/H West Wabash Avenue Balto, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physicien and for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) 4☐Pregnant at time of death this certificate has been signed by the a al director, page 2 should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 No 1 ☐ Yes 2 ☐ No 1 Yes Attending Physicien: filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes No Hospital: Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Manner of Deat 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pendina 1 Natural 2 Accident death. investigation 1 Yes 2 No or Attend after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funerel D Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number Name and address of person who completed cause of death (Itom 23a) (Type, Print) 516 N. Rolling Rd. #106 Catonsville, MD 21228 Albuerne, M.D Marcelino 31. Date filed (Month, Day, Year) SEP 1 3 2005 32. Registrar's Signature State 1 Registrar

Joe	el Robii	nsc	1 - State Unpend Item Registrar	State of Maryland 23a,27,28a-f pe	r me	irtment of E	lealth and N -05 tas Death	fental Hyg	giene 2005	29755
	Physici	an	Decedent's Name (First, Middle, La	•				2. Date of Dea Month	ith Day Year	3. Time of Death
	/Medio		J	oel Robinson						05 8:15 A ^M
	Examir	er	4a. Facility Name (If not institution, gi			4b. City, Town, or	Location of Death	-	4c. County of Dear	h
			3146 Gracefield			Beltvil			Prince Ge	
	Funeral Director		000-01-3047	Sex. 7. Age (in yrs. la 1 ☑ M 2 ☐ F 8 9		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day NOV 27	9. Birt (, Year) 9. Birt (, 1915 Ne	hplace (State or Foreign untry) W York
,	and *		Usual Residence of Decedent 10a. State 10b. County	10c. City	Town or Lo	cation				10d. Inside City Limits
	Sa-f eho	ctor	Maryland Montgo			Silver	Spring			1 □ Yes 2 No
	deeth with the Maryland me 23a or 28a-f ehow Firmst Le notified at	Funeral Director	3146 Gracefield	l Road, Apt. 203	3	10f. Zip Code	20904		10g. Citizen of What Co USA	•
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ğ	illed Hygi other	Bec	17. Father's Name (First, Middle, Las	t)					Maiden Sumame)	
la	Mental Mental arked o	TO B	David Robin	son			Paul	ine Blo	oomberg	
ary	should h		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	g Address (Street			r, City or Town, State, 2	lip Code)
Σ	and 2 valth :		Lawrence M. R	obinson/Son	750	4 Holly	Avenue	Takoma	a Park, M	D 20912
Baltimore,	Peges 1 ent of He nt: if iten ry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci	☐Removal from State ce.	metery, cren	sition (Name of natory or other place matory T	nc. 9/12		20c. Location - City or Baltimore.	
Balti	permit. Peges 1 end 2 should be Department of Health and Menta Important: if item 27 is marked eny injury or other treumatic e- 2002.		21. Signature of Funeral Service-bice Edward A. Green		22	Cremation	s of Facility Society	of MD,	Inc. more, MD 2	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that caused the death,	Do not ent S COMP Cardi	er the mode of dyin	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
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rds, P	w requires that the de been signed by the should be deteched	b	Part II. Other significant conditions	contributing to death but not resul	ting in the ur	nderlying cause give	on in Part I.		bacco use contribute to	
Vital Record	The lar	Completed						24a. Was a autops perform	ned? prior to death?	topsy findings available ompletion of cause of
/ita	Physician: Th this certificete ral director, pag	Be (25. Was case referred to medical examiner?			1	26. Place of Death			
d	Physic this c	၉	1 XYes 2 ☐ No	Hospital: 1 Inpatient 2 E			4 Nursing Ho		ence 6 XOther (Spec	#Scene
	ing After une	ertification;	27. Manner of Death 1 □ Natural 5 □ Pending 2 1 Accident investigated	(Month, Day Year) 9–10–2005 7	28b. Time of Injury	AM 28c. Injury Work	at (? Yes 2 X ⊒No		ow injury occurred fell down s	steps
ĕ	itel or Attend irs after death rai Director: ,	rtific	3 Suicide 6 Could not to 4 Homicide determined		ne, farm, stre	eet, factory, office		28f. Location (St City or Town	reet and Number or Ru	ral Route Number,
	rs af	Ce		Scene			T	eltsvil	le. Md Gra	ce Field Rd.

29a. Certifier (Check only one)

29b. Signature and title of certifier

Medical Certi

To the Hoepitel or Al within 24 hours after or To the Funeral Direc completely filled in by

State Registrar ANA

29c. License number OCME

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) September 11, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street Baltimore, Maryland 21201

Beltsville,

32 Registrar's Signature 31. Date filed (Month, Day, Year)

MD

			For State Registrar	State of Maryl		artment of F		Mental Hy	giene 0	05 29756
100	Physici /Medio		1. Decedent's Name (First, Middle, L Carlton M. Ston	e				2. Date of De Month Septemb	Day	Year 3: 10 A M
	Examir Funeral	er	4a. Facility Name (If not institution, g Which Memoria 5. Social Security Number 6.	al Hospital Sex. 7. Age (In)	yrs. last birthday)	4b. City, Town, or Ball	Himone If Under 24 H	ath	4c. Count	N/A 9. Birtholace (State or Foreign
*	Director		219.62.2086 Usual Residence of Decedent 10a. State 10b. County	1 ⊠ M 2□F	43 Yrs.	Months Days	Hours Mi	n. 8. Date of Bi	1942	Jamaica
	the Maryla 28a-f shor	Director	MD Number	VA		Baltimo	re		10g. Citizen of	10d. Inside City Limits 1 XYes 2 No
	ath with	rai Di	1010 Wicklow				21229		И	SA
9000	hours after death with the Maryland turst', or items 23a or 28a-f show at Exacilizar must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 (2 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐No	ispanic Origin? in, Mexican, Pue Specify:	(Specify Yes or No erto Rican, etc.)	Specif	ce - American Indian, ck, White, etc. iy: Plack
Maryland 21215-0036	d within 72 piene. r then "nei toe Medic	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)	Education trade completed) College (1-4or 5+)	(Give	dent's Usual Occup. kind of work done of DO NOT use retired	during most of w	rorking		Improvement
yland	should be filed and Mental Hygie marked other umatic event. It	To Be C	17. Father's Name (First, Middle, Las				Iris	ame (First, Middle Benne	#	
	nd 2 s lith ar 27 is r trau		Pauline Stone	Wife	1010	ng Address (Street a	Rd.	Baltini	er, City or Town	, State, Zip Code) 21229
Baltimore,	permit. Pages 1 ar Department of Hea Important: If Item any injury or otha once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	□Removal from State cify)	Lorrain	natory or other place Park	- 09	· 12·05	Balti	none MD
Bal	permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Service Lic	ansee	2:	2. Name and Addres Daugho Co SISI Baltin	is of Facility Greene nore Na	Funeral S	servicos e Balto	o, MD 21229
*	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition	mplications that caused the d y one cause on each line.	death. Do not en	er the mode of dyini	g, such as cardi	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con		P. VIII				
8760,	cate be executed physician and sihe burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a con						
9	artificate ing phys a as the		IF FEMALE:	d						
P.O. Box	iaw requires that the death certifica as been signed by the attending ph 2 should be detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)				te of delivery onth Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause give	en in Part I.		obacco use cont Yes 2 12 No	inbute to the cause of death? 3 Probably 4 Unknown
al Records,	The lite has age	Completed						24a. Was autop perfo 1 Yes	osy ormed?	Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No
f Vit	Physician: r this certifica ral director, p	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	2 🗌 ER/Outpatier	nt 3 DOA Othe	10	eath (Check only of Home 5 Resident		et (Specify)
Division of Vital	Hing After	Certification;	27. Manner of Death 1 Avatural 5 Pending 2 Accident investigate 3 Suicide 6 Could not	1	r) 28b. Time o	Work			now injury occur	
Divi	- 9 -	Certifi	4 Homicide determine		At home, farm, str ecify)	eet, factory, office		28f. Location (- City or Tox	Street and Numb vn, State)	er or Rural Route Number,
	To the Hospital of within 24 hours aff To the Funeral Discompletely filled in	Medical	29a. Certifier 1 ★ Certifying F (Check only one) 1 ★ Certifying F 2 ★ Medical Example 1	Physician: To the best of my aminer: On the basis of exam and manner stated.	knowledge, death	n occurred at the tim vestigation, in my op	e, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) and ma date and place,	anner as stated. and due to the cause(s)
	To the To the comp	M	29b. Signature and title of certifier			29c. License				d (Month, Dey, Year)
,	20		CAEKENSIN	D		AT 243	3746	-F52 S	Seprembe	er 7, 2005
h. ·	クし		30. Name and address of person who	completed cause of death (Item 23a) (Type,	Print) Chien	renusy	Mwachin	emere M	D. Union Memorial
	Sta		31. Date filed (Month, Day, Year) SEP 1 3 2005	32. Registrar's Si	ignature	J. Balton	10/5 1.10	ry rand L	14151	
	Registr	ar	OFL T 9 5003	Address St.	Salar Salar	and the same of th				

			1 - For State Registrar	State of I	Marylar	nd / Depa <i>Cei</i>	artme <i>rtifica</i>	nt of H	lealth ar Death	nd Me		giene Reg. No.)5	29757
			Decedent's Name (First, Middle, La	st)							2. Date of De	ath			3. Time of Death
	Physici /Medic		Florence Anna	Steele							Sept.	Day	, 2005	Year	10:15 a M
	Examin		4a. Fecility Name (If not institution, giv				4b. Cit	y, Town, or	Location of	Death	ocpe.		County o	f Death	10.15 a
			Wilson Health Ca						rsburg				Mont	gom	ery
	Funeral		5. Social Security Number 6. S	ex 7. □M 2∏ F	Age (In yrs. 96	last birthday) Yrs.	Month Month	er 1 Year S Days	If Under 24 Hours	Min.	8. Date of Bir (Month, Da Aug • 1	th <i>y, Year)</i>	000	Cour	lace (State or Foreign atry)
щ	Director		578-62-4963 Usual Residence of Decedent	- A		113.					Aug. 1.	5, 1	909	Ohi	0
	/land		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							1	0d. Inside City Limits
	Mar.	ţ	MD Montg	omery	G	aither	sbur	g							1 ☐Yes 2 ☐ No
	or 28	Director	10e. Street and Number				10f. Z	ip Code				10g. Citi	izen of Wi	nat Cour	ntry?
	23a		201 Russell Aven	ue				20	877			1	Unite	ed St	tates
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "naturel", or items 23a or 28a-f ehow other treumatic event, Ite Modical Existing frequents the righth of all other treumatic event, Ite Modical Existing frequents.	by Funeral	Marital Status Never Married 2 Married Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	ss?			edent of Hi ecify Cuba 2 No	spanic Origir n, Mexican, I Specify:	n? (Spec Puerto R	ify Yes or No lican, etc.)	•	14. Race Black Specify:	White,	etc.
Š	2 hou	ted	15. Decedent's E			16a. Dece	dent's Us	ual Occupa	ation			16b. Ki	ind of Bus	iness/Inc	dustry
215	within 7 iene. then "n	Jple	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4)	or 5+)				furing most o	of workin	9				
7	filed wil Hygien Sther th	Completed		3		h	omem	aker					home	!	
nd	be filed ital Hygie of other	Be	17. Father's Name (First, Middle, Last, Howard Stacey								(First, Middle,		Sumame)	
<u>Y</u>	2 should be and Mental Is marked eumatic ev	은									angshav				
Mar	12 sh h and 7 Is m	1	19a. Informant's Name/Relationship (• •							Route Number			tate, Zip	Code)
e,	1 and Health em 27 ther 1	1 10	F. Elizabeth Stee	ele/Daugh		DOU.			Avenue	Ba Da	1timor		D 2 cation - C	1206	
altimore,	ages nt of l		1 ☐ Burial 2 🛱 Cremation 3 ☐		ite	cemetery, crer	natory o	other plac		/8/0					
턡	artme ortant njury		 4 □ Donation 5 □ Other (Specif 21. Signature of Funeral Service User 			esapeal			ory sof Facility	7070	,5	Del	ltsvi	iie,	, אוט
Ba	permit, Pages 1 and 2 Department of Health a Important: If item 27 li any injury or other tre once.		VIA QUI	7	M0038					Cre	mation	Ser	vice	s	
			23a. Pert1. Enter the disease, or com	plications that cause	sed the deat	th. Do not ent	33 G	ist A	venue g, such às ca	Sily	respiratory a	ing,	MD		roximate
	Pnysician		Immediate Cause (Final	one cause on eac	h line.									- 10	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		un oni			_						-	3 days
	Examiner			Ath		lerosis	3								15 years
	بسيب	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that interest and the cause (Disease or injury)	b. Due to (or	as a conseq	quence of):									-)
	rcuted nd transi	Examin	(idt lilitigted events	c.											
90,	e exe sian a urial-		resulting in death) Last	Due to (or	as a conseq	quence of):									
8760,	cate be executed physician and the burial-transit	dical		_ d.									decid to	-	
9	eath certific attending p	0)	IF FEMALE:	23c. If yes, outcor	me of pream	2004									
Вох	death certifi e attending id for use as	Physiclan/M	23b. Was decedent pregnant in the past 12 months?	1☐Live birth	2 Feta	al death 3	Ectopic Other (pregnancy				2	23d. Date Mont		ry Day Year
O.	that the de led by the a detached t	ıysic	1 □ Yes 2 XNo 9 □ Unknown	9☐ Unknow		Jean 5_	J Other (.	specify							
٩	that ed b deta	by Pt	Part II. Other significant conditions of	ontributing to deat	h but not res	sulting in the u	nderlying	cause give	en in Part I.		23e. Did to	obacco u	se contrib	ute to th	e cause of death?
rds	requires that sen signed b hould be deta										1 🗆 1	/es 2[XNo 3	Prob	ably 4 Unknown
Records,	aw requir Is been si 2 should	ompleted									24a. Was	an	24b. We	ere auto	osy findings available
Re	he ha	l Lio										rmed?	pri de	or to cor ath?	npletion of cause of
Vital	10 17	e C	25. Was case referred to medical						26. Place of	f Death	1 ☐ Yes Check only o	2 <u>₩</u> No ne)		Yes	2LJ N0
f <	.s .b	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inp	atient 2	ER/Outpatien	it 3 🗆 0	Othe			e 5 Resid		3 Other	(Specify	')
n of			27. Manner of Death 1 Natural 5 □ Pending	28a. Date of I	njury Day Year)	28b. Time of Injury		28c. Injury Work	at		d. Describe h				,
Sio	Attending r death. ector: Afte by the fune	catio	2 Accident investigation	1			М	1 🗆 1	res 2 □ No)					
Division		ertification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of	Injury - At h etc. (Specil	ome, farm, str fy)	eet, facto	ry, office		28	If. Location (S City or Tox			or Rura	Route Number,
	Hospitel or 14 hours afte Funerel Dir tely filled in	O								4					
	e Hospitel 24 hours e Funerel etely filled	ledicai	29a. Certifier 1XXCertifying Pr (Check only 2 Medical Exer	ysician: To the be	s of examina	owledge, death ation and/or in	occurre vestigatio	d at the tim n, in my op	e, date and p pinion, death	place, ar occurred	d due to the d at the time,	cause(s) date and	and mann place, an	er as sta d due to	ated. the cause(s)
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Med	29b. Signature and title of certilier	and manner	əlateti.		2	9c. License	number			29d, Date	e signed /	Month I	Day, Year)
	F 3 F 8		· VILL	vulds	V-			D0031					. 6,		
	501		30. Name and address of person who	completed cause	of death /Iter	n 23a) (Type	Print)					- CPL	. 0,	200.	
	of of	1	01 1 1	nner, M		201 Rus		Aver	ue Gai	ithe	rsburg	, MD	208	377	
	Sta	ite	31. Date filed (Month, Day, Year)	2. Reg											
	Regist	rar	SEP 1 3 200	5 The 16	1	ature									

JC Richard Ellsworth Silver Jr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For Registrar State 23a&27 per me G848 10-14-05 tas Certificate of Death 29758 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10,_ September 2005 07:20 AM Richard Ellsworth Silver, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 2819 Maudlin Ave. Baltimore n/a 8. Date of Birth (Month, Day, Year)

Tully 31,1955 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1**X** M 2 □ F 50 Director 220-64-3062 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "neturel", or items 23s or 28s-f show the Medical Examiner must be notified at Maryland n/a Baltimore 1 Yes 2 □ No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2819 Maudlin Avenue 21230 United States death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1972-74 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White à Specify: 3 Widowed 4 X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. 1Elementary/Secondary (0-12) College (1-4or 5+) heat tree operator piston rings is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi end Mental H Richard Silvers, Sr. Gloria Juanita Laughare 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 st Depertment of Heelth end Important: if item 27 is n any injury or other traun Angela Olay - sister 8039 Pine Ridge Road, Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location · City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 9/16/2005 Brooklyn Park, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Serv 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one or use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardiomegaly /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. the ettending physicien by Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No deteched 9 Unknown 9 Unknown δ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 1 ☐ Yes 2 🗆 No 3 Probably 4 □Unknown Completed been : 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an hes page 2 certificate 1 Yes 2 No funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To Yes 2□ No 1 Inpatient 2 ☐ ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident ofter deatl Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 2 To the ţ 29b. Sigrature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 2 Munite O.C.M.E. September 10, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pysonos

State Registrar 31. Date filed (Month, Day, Year)

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DHMH 17 Rev 1/2001

ORIGINAL

REU

32. Registrar's Signature

forti

111 Penn Street, Baltimore, Maryland 21201

			For State Registrar		State	of Maryla	ind / Depa <i>Cei</i>	artment of <i>tificate of</i>	Health ai <i>Death</i>	nd Mental H	ygiene 2	005	29759
Ì	Physici /Medic		1. Decedent's Name Hattie L		,					2. Date of I Month Septer	Death Day	Year 2005	3. Time of Death
0.	Examin		4a. Facility Name (If 2115 Oakl		street and nu	ımber)		4b. City, Town, Middl	or Location of e River	Death	4c. Co	unty of Death	
	. Funeral Director		5. Social Security No. 220 04 51		ex □ M 2]x F	7. Age (In yr 85	s. last birthday) Yrs.	If Under 1 Year Months Days		Min. (Month, I	Birth Day, Year) 28,1919		olace (State or Foreign htry)
	aryland show	_	Usual Residence of 10a. State	10b. County		10c. (City, Town or Lo					107	Od. Inside City Limits
	th the Ma or 28a-f	Directo	Maryland 10e. Street and Num	Baltimon	re		Middle	10f. Zip Code		-	10g. Citizen	of What Cour	1 ☐ Yes 2√2 No itry?
	ns 236 (min)	Funeral D	2115 Oakl	and Rd.	12. Was Dec	edent Ever in	U.S. 13. \	212 Vas Decedent of		n? (Specify Yes or h	1	USA Race - Americ	an Indian
036	hours after death with the Maryland turel', or Items 23s or 28a-f show al Examinar must be notified at	by		ed 2 Married 4 Divorced	Armed F	orces? 2 X No ive	'	f Yes, specify Cul		n? (Specify Yes or N Puerto Rican, etc.)		Black, White, ecify:Whit	etc.
1215-0036	72 ne	Completed	Elementary/Secon	15. Decedent's Edify only highest grandary (0-12)	de completed,) (1-4or 5+)	(Give	lent's Usual Occu kind of work done DO NOT use retire	pation during most of ad)	of working		of Business/Ind	fustry
Maryland 2	Hyg Hyg sthe	Be Co	17. Father's Name (First, Middle, Last)			П	Juenaker.	18. Mother	s Name (First, Midd	Own I	= IIIII A	
ız	should bd Men marke metic	To	Herbert 19a. Informant's Na		Type, Print)		19b. Mailin	a Address (Stree		a Bowen or Rural Route Num	ther City or To	we State 7in	Code
	s 1 and 2 and Health are item 27 is other treu		Bernadett	e Greave			_ 1 Rus	ssell Fr		ırt Baltin	nore, M	d. 21 221	
Baltimore,	Pages 1 nent of H ent: If ite ury or ot			iosition Cremation 3 5 Other (Specif		State		sition (Name of natory or other pla Redeeme		Date 15/2005		on-City or To Tore, M	wn, State aryland
Balt	permit. Pages Department of Importent: If it eny injury or once		21. Signature of Full	meral Service Licer	T Rous	sko.	Bı	Name and Addr CUZdZins	ki Fune	eral Home Avenue E	P.A.	vd. 212	221
Ī			23a Part1. Enter the shock, or hear Immediate Cause (I	trailure. List only	plications that one cause on	each line.	ath. Do not enti	er the mode of dy	ing, such as ca	ardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician / /Medical Examiner		disease or condition resulting in death)	(a Due to	(or as a cons	equence of):	dial i	n-lave.	tion dis		*	
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/ ວັ	icate be executed physician and the burial-transit	Examiner	cause. Enter Under Cause (Disease or i that initiated events resulting in death) L		c	(or as a conse	equence of):						
09/89	ificate be g physicia as the bur	ledicai			d								
O. Box (death cert e attending id for use a	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 5 9 ☐ Unknown	months?	1 Live	itcome of preg birth 2 Fe nant at time of nown	ital death 3 □	Ectopic pregnand Other (specify)	гу		23d.	Date of deliver Month	ny Day Year
ecords, P.	requires that the de een signed by the a hould be detached f	by	Part II. Other signifi	cant conditions c	ontributing to c	death but not re	esulting in the ur	nderlying cause gr	ven in Part I.		tobacco use c		e cause of death?
r	The law ate has b page 2 si	Completed									opsy formed?	b. Were autop prior to con death? 1 \(\sum Yes	osy findings available apletion of cause of
Vital	Physicien: Th this certificate ral director, pag	To Be	25. Was case referrexaminer? 1 ☐ Yes 2 ☑ 1	Î	Hospital:	Innationt 2	☐ ER/Outpatien	t 3□ DOA Ot		f Death Check on ing Home 5 ☑ Res	one)		
on or	ding Phys	tion: T	27. Manner of Death	5 Pending	28a. Date (Mor		28b. Time of Injury	28c. Inju	ry at rk?	28d. Describe	how injury oc		
DIVISION	I or Attending after death. Director: After I in by the fune	Certification:	2 Accident 3 Suicide 4 Homicide	investigation 6 Could not be determined	28e. Place	e of Injury - At ling, etc. (Spec	home, farm, stre cify)	eet, factory, office	Yes 2 No	28f. Location	(Street and Nu own, State)	imber or Rural	Route Number,
	To the Hospital of within 24 hours af To the Funerel D completely filled in	edicai C	29a. Certifier (Check only one)	1 X Certifying Ph 2 ☐ Medical Exan	liner: On the b	e best of my ki pasis of examination of stated.	nowledge, death nation and/or inv	occurred at the ti estigation, in my	ime, date and popinion, death	place, and due to the occurred at the time	e cause(s) and o, date and place	manner as sta ce, and due to	ated, the cause(s)
	within To th	ž	29b. Signature and	title of certifier	a - P11	1		29c. Licen:		-2	d/1	aned (Month, E	Day, Year)
	0,		30. Name and oddre	es of person who	completed cau	se of death (Ite	ет 23а) (Туре, І	Print)	3465	Chit	711	1100	1. Med 1128
dy.	Sta	te	31. Date filed (Mont	1.03EP11	50 2005 ^{32. 5}	OC Hadiologi's Sign	nature A	dent	er I	N - 316	17err	y Houl	. Mcd
	Registr	ar			4			4					

State of Maryland / Department of Health and Mental Hygien 2051 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death o. Hner **Physician** Month d september 6:45PM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Upshington ledical GEN BORNIE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 216-16-905 Director DEC. 31, 19 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Myclical Examiner must be notified at Millersville 1 ☐ Yes 2 No Be Completed by Funeral Director Anne Arande 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? asadena 12. Was Decedent Ever in U.S. Amed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No worlduar white Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th 15/ectnician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event SDGS. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3613 Jucker Bacto and. Donna friend Annapolis Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) metro Juneral Service Licen 22. Name and Address of Facility 21. Signature bernheusease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, beart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Medical Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2**X** No 3 Probably 1 Tes 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 \(\sum \) Yes 2\(\overline{\pi}\) No autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3□ DOA within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier, D0032744 30. Name and address of person villo completed cause of death (Item 23a) (Type, Print) GAVIRIA 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar 3 2005

		ľ	1 - State Registrar	State of Maryli	and / Dep $C\epsilon$	artmer e <i>rtifica</i> :	nt of He te of D	ealth and <i>Peath</i>	Mental H	ygiene Reg. No		29761
	hysici		1. Decedent's Name (First, Middle, La	Schleigh					2. Date of D Month	eath Da		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give 8917 EMCA			4b. City	•	Location of Dec	ath		County of Deal	
	ineral ector		5. Social Security Number 6. S		rs. last birthday	/) If Unde Months	r 1 Year	If Under 24 Hi Hours Min	rs. 8. Date of B	irth Day, Year	9. Birt	hplace (State or Foreign untry) SSACHUSETS
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	sician edical		disease or condition resulting in death)	a. Me Fuso Due to (or as a con:	sequence of):	Color	~ G	wita				2 pros
Exar	niner	Xi.	Sequentially list conditions.	b. Aremi	a							
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J 4	2 = 1		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre							23d. Date of deli	very
the deat	y the atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1 Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown		□Ectopic p □ Other (s,					Month	Day Year
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raquir	should	eted							1	Yes 2	□No 3□Pro	babiy 4 \Unknown
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el or Att	od in by t	Certification:	3 Suicide 6 Could not be determined	28e. Pface of fnjury - A building, etc. (Spi	it home, farm, s ecity)	treet, factor	y, office		28f. Location City or To	(Street ar own, State	nd Number or Ru e)	ral Route Number,
To the Hospitel or Attending Physicien: The law requires that the death certively hours after death.	To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one) 1 ☑ Certifying Pl	hysician: To the best of my miner: On the basis of exam and manner stated.	knowledge, dea nination and/or i	th occurred nvestigation	at the time	o, date and place nion, death occ	ce, and due to the	cause(s , date and) and manner as d place, and due	stated. to the cause(s)
To the	comy	Σ	29b. Signature and title of certifier	-1 , ha			c. License	1			te signed (Monti	
11	1			This I'D	Itom 22-1 (T	Del-M	19.	3/72		4	112/2	005
10			30. Name and address of person who	Fell 50	S Fa	, Print)	and	Ave.	Tansa	M	P 212	286
F	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 3 2	completed cause of death (in the completed cause of death (in the complete cause of death (in	gnature	Carli	1			1		

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		•	For State Registrar amend item 1. Decedent's Name (First, Middle, Last)	State of Maryland /	Depa	rtment of He	ealth and I		giene 2005	29762
			1. Decedent's Name (First, Middle, Last)	#17 per in go4	1 -57.2	Trop on -		2. Date of Dear	th	3. Time of Death
	Physicia /Medic		Williemae			Smith		Month 9	1 2005	10:40a M
	Examin		4a. Facility Name (If not institution, give s Hamilton N.H			4b. City, Town, or Balt	ocation of Death		4c. County of Death	י
	Funeral Director		5. Social Security Number 6. Sex 262-38-2601	7. Age (<i>In yrs. last l</i>	vrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 5-2-	Year) 9. Birth	nplace (State or Foreign untry) Ga •
	pur *	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn ort or	ation				10d. Inside City Limits
	Maryli f sho	5	Md. NA			timore				1 X Yes 2 □ No
	r 28a-	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	untry?
	h with	a D	6040 Harford	Road		212	214		USA	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heelih and Mental Hygiene. If item 27 is marked other than "netural", or ttems 23a or 28a-f show or other treumatic event, the Madical Examinatinatic bundliked at	y Funeral	11. Marital Status 1 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	lf If	/as Decedent of His Yes, specify Cuban ☐ Yes 2 ☐ No	panic Origin? (S _I , Mexican, Puerto Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race - Ame Black, White Specify: B	
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) OU	to v	ND	DZ	1464		9/12/0	2
	1T	- 1	30. Name and address of person who cor	npleted cause of death (Item 23a	(Type, F	Print)	. 0-1	1 2-0	001 = 1 = 1	
-	1	Ì	SHOAIIS A HA	1214W1 WD, 8	32(1	U. GUTA	NO 21 72	NE 204/	134C(Indi	LE MD 2120

To the Hospital or Attending Physician: The law red within 24 hours after death. To the Funaral Diractor: After this certificate has been completely filled in by the funeral director, page 2 shou	To Be Complete	25. Was case referred to medical examiner? 1 □ Yes 2 ★No	Hospital:	Innationt 2] ER/Outpatier	nt 3□ DOA	0.4	— a p	utopsy erformed? es 2 No nly one)	prior to death? 1 Yes	2 X No	s available cause of
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2 should and Mei is mark aumatic	J.	19a. Informant's Name/Relations			19b. Maili		reet and Number o	or Rural Route Nu		or Town, State, Z	Tip Code)	03.00
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Funeral		5. Social Security Number	OOK St. 6. Sex 1□M ¾ □F	7. Age (In yrs. 90	. last birthday) Yrs.	If Under 1 Y	ear If Under 24	Hrs. 8. Date o	f Birth		hplace (State	or Foreign
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			e, Last)		Che	.11		Month	Da			of Death
	The law requires that the death certificate be executed TO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland TO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland TO permit. It is marked other than 'natural', or items 23a or 28a-f show the TO permit of the TO permit or other traumatic event, Its Margest Examiner must be notified at the TO permit or other traumatic event, Its Margest Examiner must be notified at the TO permit or other traumatic event, Its Margest Examiner must be notified at the TO permit of the	The law requires that the death certificate be executed Table 1 and 2 should be filed within 72 hours after death with the Maryland Department of Hastin and Mental Hygiene. In portant: If them 2 should be filed within 72 hours after death with the Maryland Department of Hastin and Mental Hygiene. In portant: If item 27 is marked other than "natural, or items 23a or 28a-f show any injury or other traumatic event, its Medical Examiner must be notified at once. To Be Completed by Physician/Medical Examiner	Physician /Medical Examiner 1. Decedent's Name (First, Middle Ida Ida Ida Ida Ida Ida Ida Ida Ida Ida	Physician Medical Examiner 1. Decedent's Name (First, Middle, Last) Ida 4a. Facility Name (If not institution, give street and management of the proof of the	Physician Ida Ida Ida Ida Ida Ida Ida Ida	Physician Indeededn's Name (First, Middle, Last) Indeededn's Name (First, Middle, Last)	Topic Topi	Physician Medical Examiner Total Shell She	Physician Ida Shell Ida Ida Shell Ida Ida Shell Ida Id	Physician Middel Examiner 1. Decedent's Name (Frist, Middie, Last) 1. Decedent's Name (Frist, Middie, Middie, Last) 1. Decedent's Name (Frist, Middie, Middie, Last) 1. Decedent's Name (Frist, Middie, Middie, Last) 1. Decedent's Name (Frist, Middie, Middie, Last) 1. Decedent's Name (Frist, Middie, Middie, Last) 1. Decedent's Name (Frist, Middie, Middie, Last) 1. Decedent's Name (Frist, Middie, Middie, Last) 1. Decedent's Name (Frist, Middie, Middie, Last) 1. Decedent's Name (Frist, Middie, Middie, Last) 1. Decedent's Name (Frist, Middie, Middie, Last) 1. Decedent's Name (Frist, Middie, Middie, Last) 1. Decedent's Name (Frist, Middie, Middie	Physician Medical Examiner As Facility Name (if not institution, give street and number) 17.26 HOlbrook St. 10. Specify Till Market (if not institution, give street and number) 10. Specify Name (if not institution, give street and number) 17.26 HOlbrook St. 10. Specify Name (if not institution, give street and number) 10. Specify Name (if not institution, give street and number) 17. Age (in yrs. last birthday) 10. Specify Name (if not institution, give street and number) 10. Specify Name (if not institution, give stree	Physician // Modical Examiner Physician // Modical Examiner I Case of Deam / Section of Day / Section /

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	Funeral Director		5. Social Security Number 217–14–9464	1□M 200F	e (In yrs. last birtl 89	nday) If Under 1 Year Months Days		lin. 8. Date of B	17-16	9. Birthplace (State or Fore Country) Md.	aign
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ore,			20a. Method of Disposition		20b. Place of	Disposition (Name of crematory or other pla		Date		- City or Town, State	
Ē	Page ent c nt: if		1 Burial 2 Cremation 4 Donation 5 Other (Sp.			son Fores		9-16-05	Owing	gs Mills, M	d.
Baltimore,	permit. Page Department of importent: if any injury or once.		21. Signature of Funeral Service L	icensee Wan	Con	22. Name and Addre	ess of Facility	Balt	imore,		
			23a. Part1. Enter the disease, or shock, or heart failure. List of	omplications that caused only one cause on each li	the death. Do no	ot enter the mode of dyi	ng, such as card	liac or respiratory	arrest,	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition resulting in death)	-a 20	RDis					Onset and Death	۔ لابر
1	/Medical Examiner		resulting in death)	Due to (or as	consequence o	D: 50 0	7 60			3 11 veck	8
Me		e	Sequentially list conditions, if any, leading to immediate	b. Que to (or as	a gonsequence o):) (7			7,000	
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that iniliated events		U		\vee				
o,	e exec ian ar urial-tu	EX	resulting in death) Last	Due to (or as	a consequence o):					
68760,	icate be executed physician and s the burial-transit	dlcai	8	d							
Box	death certif e attending d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 ☐Ectopic pregnanc 5 ☐ Other (specify) _	у			ate of delivery onth Day Year	
P.0	res that the de signed by the a l be detached f		Part II. Other significant conditio	ns contributing to death b	ut not resulting in	the underlying cause give	ven in Part I	23e. Did	tobacco use cont	tribute to the cause of death?	
ecords,	w requires that the been signed by the should be detache	ted by			,				Yes 2□No	3 Probably 4 Unknow	
α	The la	Completed						24a. Was auto perf 1 \(\text{Yes}	ormed?	Were autopsy findings availal prior to completion of cause of death? 1 ☐ Yes 20/No	ble of
Vita	Physicien: Th r this certificate rral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		CH	. 4	eath (Check only			
o	Phys rthis ral di	-: To	1 Yes 2 No 27. Manner of Death	1 🗆 Inpatie			4 X/Nursing	Home 5 Res	how injury occurr		
lon	at te	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investig		y Year) In	ury Woi	rk? Yes 2 □ No	200. 00301100	now injury occurr		
Division of Vital	or Attendi after death. Director: A in by the fu	Certification:	3 Suicide 6 Could n 4 Homicide determi	ot be ned 28e. Place of Injuiding, etc	ury - At home, fari c. (Specify)	n, street, factory, office		28f. Location City or To	(Street and Numb own, State)	per or Rural Route Number,	
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one) Certifying 2 Medical E	Physician: To the best examiner: On the basis of and manner sta	examination and	death occurred at the tir for investigation, in my o	me, date and pla opinion, death oc	ace, and due to the courred at the time	cause(s) and ma , date and place, a	anner as stated. and due to the cause(s)	
	To the To the complex	Me	29b. Signature and title of certifler	Tripe	neren	29c. Licens	3066	/	29d. Date signed	d (Month, Day, Yeart	15
	17		30. Name and address of person v	who completed cause of d	eath (Item 23a) (T	ype, Print) Balli	3066 mole	· Mo	d-21	239	
THE RESERVE TO SERVE	Sta Registi	- 1	31. Date filed (Month, Day, Year) SEP 1 3 200	32. Registra	ar's Signature	de					

State of Maryland / Department of Health and Mental Hygien 2005 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month Stanson 4:33 AM rances September 6 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Hospital Baltimore n/a If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🖾 F Months 212-34-8319 Director 67 Yrs. 26, 1937 Maryland Sept. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Items 23a or 28a-f show the Medical Example of most be notified at Yes 2 No Completed by Funeral Director MD Anne Arundel Glen Burnie 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural," or Items 23a any injury or other traumatic event, its Medical Ferral 2006. 21061 6506 South Charter Rd. Apt. D.

1. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white 1 Yes 2 No Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 9th College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Anthony Seneck Theo Hiser

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6506 South Charter Rd. Apt. D. Glen Burnie, Md21061 pe of Disposition (Name of Date 20c. Location - City or Town, State Samuel James Stanson- Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3_Removal from State Loudon Park cemetery Sept.9, 05 5 Other (Specify) BAltimore City 21. Signature of une Se 22. Name and Address of Facility Loudon PArk Funeral Hone \$620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part1 Enter the disease, or com shock, or heart failure. List only ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to for as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner nding physician and use as the burial-transit to the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 menths?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other 1 Inpatient P 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 Yes 2 No hours after death. investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and alle of certif 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Seyed Morfeza Farasat, MD 3001 NS. Han 3 3001 is. Hanover St. Ballimore, MD

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

3 2005

			1- For State of Maryland / Depa Central Centra	rtment of Health and M tificate of Death	_	ⁿ 2005	29766
	Physici		Decedent's Name (First, Middle, Last) DOROTHY V. SABOURY		2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	SEFI. I	0 2005 4c. County of Dea	3:30p M
			PICKERSGILL	TOWSON		BALTIM	ORE
	Funeral Director		5. Social Security Number 219-18-0085 G. Sex 1 M 2 F 7. Age (In yrs. last birthday) 97 Yrs. Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 03/10/1	9. Bir 908 MA	thplace (State or Foreign ountry) RYLAND
	yland now		10a. State 10b. County 10c. City, Town or Loc	ation			10d. Inside City Limits
	e Mar	ctor	MD BALTIMORE TOWSON				1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Co	ountry?
	s 23£		615 CHESTNUT AVE	21204		USA	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene item 27 is marked other than "natural; or items 23c or 28e-f show other traumatic avant. If a Modical Executed retriation at	by Funerai	1 Never Married 2 Married 1 Yes 2 No	fas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto ☐ Yes 2 (No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	e, etc.
9	72 hou	ted	15. Decedent's Education 16a. Decede	ent's Usual Occupation	168	. Kind of Business	HITE (Industry
21215-0036	ithin 7 96.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) life. Do	ind of work done during most of working NOT use retired)	ng		,
	filed w Hygier other th		12yrs HOUSE 17. Father's Name (First, Middle, Last)			HOMEMAKI	ER
aryland	nould be f I Mental H narked of natic ava	To Be	FRANK E. EVANS	EDITH H	(First, Middle, Mai 入のロロロロ	den Surname)	
ary	2 should be and Mental Is marked aumatic av	۴		Address (Street and Number or Rura		tv or Town, State, 2	Zip Code)
≥	1 and 2 Health a tem 27 Is			MER CT. APT.10			
altimore,	jes 1 ar of Hea If item or other		20a. Method of Disposition 1	ition (Name of atory or other place)	ate 200	. Location - City or	Town, State
Ē	t. Pages tment of I tant: If it		`4 □ Donation 5 □ Other (Specify) LOUDON P.	ARK 09/14	/2005 B	ALTO. CI	TY,MD.
Bal	permit. Pages Depirtment of Important: If ii any injury or o		HE 16	Name and Address of Facility NRY W. JENKINS 924 YORK RD MO	NKTON . MT	CO.	
			23a. Part1. Enter the disease, or complications that caused the death. D not enter shock, or heart failure. List only one cause on each line.	r the mode of dying, such as cardiac o	respiratory arrest,		Approximate Interval Between
)	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	heart fail	ure		Onset and Death JCACS
	Examiner		Due to (or as a Ansequence of):	motern diso	000		July 1
	5.49	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	rojuly Crse	736		Jesus
V	ocuied nd transii	Exan iner	Cause (Disease or injury that initiated events	sein			year
8760,	cate be execuled physician and the burial-transit		resulting in death) Last Due to (or as a consequence of):				0
387	phy:	dical	d				
O. Box 6	ne death certifi the attending thed for use as	Physician/Me		Ectopic pregnancy Other (specify)		23d. Date of deli Month	very Day Year
ص.	res that the de signed by the a be detached f	y Ph	Part II. Other significant conditions contributing to gegin but not resulting in the und	derlying cause given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
rds,		ed by	DiA betes inellitus		1 ☐ Yes	2 No 3 Pro	obably 4 Unknown
Record	0 4 0	Completed			24a. Was an autopsy performed	prior to c	topsy findings available completion of cause of
Vital	i cian : Th certificate rector, pag	0	25. Was case referred to medical	26. Place of Death	1 Yes 2		2 □ No
of <	Physici this ce al direc	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	O#	ne 5 Residence	6 ☐ Other (Spec	rify)
0	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury		8d. Describe how in		
<u>s</u>	ttand death stor: /	icati	2 Accident investigation	M 1 Yes 2 No			
Division	sal or Attandius safter death. In Director: All all by the fu	Certification:	4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 See: Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office	8f. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
	To the Hospital or Attanding Physician: within 24 hours after death: To the Funeral Director: After this certific completely filled in by the funeral director,	dicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the death of t	occurred at the time, date and place, a stigation, in my opinion, death occurre	nd due to the cause d at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month	
	_	1	Il Anthony Riley, and	923005	Je	ptembe	1 2, 2005
	3		30. Name and address of person who completed cause of death (Vem 23a) (Type, Pr		f. Bal	to md	21200
	Sta	te	31. Date filed (Month, Day, Year)				
	Registr	ar	SEP 1 3 2005 June 15 April	E)			

			State of Maryland / Department of Health and 1- State of Maryland / Department of Death Certificate of Death	Mental Hyg	giene 005	29767
			1 - Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)	2. Date of Dea	ay. No.	
	Physici	an	Maggiemae Smith	Month,	, Day _ Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat	Septer	4c. County of Deal	
	LAGIIII	۱۲۱	Bultimore Washington Medical Confet Glen Burnie		Anne A	Islan
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min			hplace (State or Foreign
	Director		215-07-3451 1 M 2FF 88 Yrs. Months Days Hours Min.	5-23-	1917 M	
	land ow		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hyglene. ortant: If item 27 Is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic evant, the Medical Evarified must be notified at injury or other traumatic evant, the Medical Evarified must be notified at each	Funeral Director	MD Anne Arundel Ferndale			1 ☐ Yes 2X☐ No
	vith th	Dire	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	ountry?
	eath v	erai	505 Winton Avenue 21061–2430	`~~*· V~~ ~~ N~	U.S.A.	done to disc
	irer d	Fun	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☒ Married 1 □ Yes 2 ☒ No	to Rican, etc.)	14. Race - Ame Black, Whit	
3mith 21215-0036	within 72 hours after ane. than "natural", or Ita	þ	1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☒ No Specify:		Specify: V	White
Smith 21215-0	72 hc	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)	rkina	16b. Kind of Business	Industry
	within one.	idin	Elementary/Secondary (0-12) College (1-40r5+)			
N T	filed Hygie other	ပိ	Tayloli Clerk	me (First, Middle,	Montgomery	Wards
and	Mental Merkad c arkad c	To Be	Charles Herman Dembinsky Alma M.		,	
ary	2 should and Mer Is marks sumatic	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ri	ural Route Numbe	r, City or Town, State, 2	Zip Code)
5≥	1 and 2 Health and 21 lam 27 l		Mrs. Regina Birsner / Niece 3207 Garden Avenue, B	altimore	, MD 21227	7
a) o	of He of He If itan		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or	Town, State
	: Pag tment tant: ijury		`4 □Donation 5 □ Other (Specify) Maryland Veterans Cem. 9/1		Crownsville	•
Maggie M	permit. Pages Department of Important: If i any injury or once.		21. Signature of Tuneral Service Licensee 22. Name and Address of Facility Si			
Ž -	CH HA		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial shock, or heart failure. List only one cause on each line.			Approximate
	Physician		Immediate Cause (Final			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			Zweek
	Examiner		Sequentially list conditions b. Coulogbrue Heart Mileson	Q.		Zustath
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	be executed sician and burial-transit	хаш	resulting in death) Last Due to (or as a consequence of):			
760,	te be executed ysician and ne burial-transit	cai E				
			0.			
P.O. Box 68	or Attending Physician: The law requires that the death certifica birter death. Diractor: After this certificate has been signed by the attending ph in by the funeral director, page 2 should be detached for use as it	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the cast 18 machine? 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of del	ivery
Э.	that the death cer ed by the attendin detached for use	sicia	in the past 12 months? 1 Yes 2 10 No 9 Unknown 1 Unknown		Month	Day Year
	hat the	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23a Did to	bacco use contribute to	the sause of death?
Division of Vital Records,	w requires that been signed I should be det	d by	Read Forling (Clorone) x 3 years.		es 2 □ No 3 □ Pr	
cor	w requ	iete	Anex.	24a. Was a		topsy findings available
Re	ysician: The lavis certificate has director, page 2	dmo	Multica	autops perfor	sy prior to death?	completion of cause of
ital	iclan: Th certificate rector, pag	BeC	25. Was case referred to medical 26. Place of Dec	ath (Check only on		2□ No
Ž	Physici this ce al direc	0	1 Yes 2 No Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing F		ence 6 Other (Spec	cify)
o u	ding Phy h. After thi funeral	on:	27. Manner of Ceath 28a. Date of Injury 28b. Time of Injury at Work?	28d. Describe ho	ow injury occurred	
isio	vttendi death. ctor: A y the fu	icati	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be	201		
Div	al or Attend after death Diractor: d in by the	Certification: T	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town	treet and Number or Ru n, State)	rai Houte Number,
	To the Hospital or Atten within 24 hours after deat To the Funaral Director: completely filled in by the	alC	29a. Certifier Check call. Check call. Check call. Check call.	e, and due to the c	ause(s) and manner as	stated.
	he Ho in 24 ha Fu pletel	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	urred at the time, d	late and place, and due	to the cause(s)
	To T To 1	Σ	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mont)	
	1		Dores Millomen as 376461		Septensa	754 2685
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) I Ah was de. 31. Date filed (Month Day Ver) 32. Registrat Signature 33. Registrat Signature	CAMEV	EN, MD.	
	Sta	ate :	31. Date filed (Month, Day, Year) 32. Registrar's Signature	2206	·	
2	Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 1 3 2005			

State of Maryland / Department of Health and Mental Hygien 2005 29768 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2135 PM 05 May Virginia Snyder /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner . Agnes Boultimore HOSPHOU 5+ If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☐ M 2 💢 F Yrs. Director 219-18-1410 80 Dec. 12, 1924 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow 27 is marked other then "netural", or items 23s or 28e-f show traumatic avent, the Medical Examiner must be notified at 1 ☐ Yes 2XNo Director Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1200 Janet Drive 21040 USA Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status within 72 hours after 1 ☐ Yes 2 ☐ №0 If Yes, Give Year or Dates: 1 Never Married 200 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Itam 27 Is marked other then College (1-4or 5+) Elementary/Secondary (0-12) 10 Bookkeeper Advertising 18 Mother's Name (First Middle Maiden Surname 17 Father's Name (First Middle Last) Be UNKNOWN UNKNOWN UNKNOWN UNKNOWN UNKNOWN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1200 Janet Drive, Edgewood, Maryland 21040 Date 20c. Location - City or Town, State Gilbert C. Snyder / Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 9-9-05 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licenses J. Mark T-1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset, and Death 23a. Part 1. Enter the disease or condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final an cer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner be executed burial-transit and Due to (or as a consequence of) Box 68760, the attending physicien Physician/Medical use as the 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy detached for Month Year Day 4☐Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Hinknown á σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, å 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy rmed2 2 X No 1 Yes 1 ☐ Yes Vital director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Npatient 1 🗌 Yes 3 DOA 2 2 ER/Outpatient this ŏ funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Division 5 Pending investigation Attending Injury 1 Natural 2 Accident death. 1 ☐ Yes 2 ☐ No Director; 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by after 4 - Homicide 0 within 24 hours at To the Funeral D completely filted in Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel Signature and title of certifier 29b. 29c. License number 29d. Date signed (Month, Day, Year) 2 A. Cheema D 00 63 6 25 4312 - ULD COURT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Adnan PIKESVILLE MD 31. Date filed (Month, Day Year) 32. Registrar's Signature State 3 Registrar to specie

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			For State Registrar	State of Ma	ıryland	d / Depa <i>Cei</i>	artment of F tificate of	lealth a <i>Death</i>	and Men		ienę2 eg. No.	005	29769
	Physici	an.	1. Decedent's Name (First, Middle, Lasi)						Date of Deat Month	h Day	Year	3. Time of Death
	/Medic		Isabel Winif		egrav	es			Se	ptemb	er 9,	, 2005	9:17 A M
7	Examir	er	4a. Facility Name (If not institution, give Harford Memorial				4b. City, Town, o					County of Death	
	Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. la	st birthday)	Havre C			Date of Birth		arford 9. Birthi	place (State or Foreign
	Director		212-12-5323	DM 2□X=	85	Yrs.	Months Days	Hours	Min. Ap	Date of Birth Month, Day, Pril 2	7, 19	Cou	yland
	pur &		Usual Residence of Decedent 10a. State 10b. County		10c City	. Town or Lo	cation						10d. Inside City Limits
	Aaryla I shor	5			-10								1 ☐ Yes 2 No
	the N	rect	Maryland Harford 10e. Street and Number		Clu	rchvi]	10f. Zip Code			1-	0g. Citize	en of What Cou	ntry?
	h with	0	1006 Calvary Road				21028	}			USZ		,
	ems 2	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S	S. 13. \	Vas Decedent of H Yes, specify Cub	lispanic Ori	igin? (Specify	Yes or No-	14	1. Race - Ameri Black, White,	
36	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show iteal Examinar must be natified at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	0	1	Yes 2∭XNo	Specify:		, 0.0.,	s	anaihe:	ite
21215-0036	72 hours natural', edical Exe	led t	15. Decedent's Edu	ıcation		16a. Deced	lent's Usual Occup	ation			16b. Kind	VVIII of Business/In	
215	- 20	Completed	(Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-4or 5-	+)	(Give life, l	lent's Usual Occup kind of work done DO NOT use retire	during mos d)	at of working				,
2	filed withi Hygiene. other than	Con	8			Owne	er/Opera					Cleanin	g
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Market	Be	17. Father's Name (First, Middle, Last)	66					er's Name (Fir		daiden Si		
<u> </u>	hould be d Mental marked o	P	Albert Paul 19a. Informant's Name/Relationship (T)	Hoffmar	J	10h Mailin	g Address (Street	Effic		melia	City on 3	Keithl	4
S	s 1 and 2 should f Health and Mer ftem 27 Is marke other traumatic		James E. Segraves		3		Calvary				-		
ē,	t Health them 27 other tr		20a. Method of Disposition	11010300110			sition (Name of natory or other pla		Date	-		ation - City or To	
Baltimore,	permit Pages 1 a Department of Hee Important: If Item any in ury or othe		1 X Burial 2 □ Cremation 3 □ I `4 □ Donation 5 □ Other (Specify,		_		J.M. Chur		9/13/	05 (hurc	chwille	, Maryland
alti	permit Pa Deparmen Important: any in ury		21. Signature of Funeral Service Licens	99	1		. Name and Addre					ral Hom	
<u> </u>	Dep Imp		Hills Miller	nastelli	yti				Road,	Abing	don,		and 21009
			23a. P. rt1. Enter the disease, or composhock, or he modilure. List only of	lications that caused in ne cause on each line	the beath. e.	. Do not ente	er the mode of dyin	ng, such as	cardiac or res	spiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Dissel	min	ated	intral	163CL	Var a	0094	Jop	athy	Onset and Death
ı	/Medical Examiner		Todattary III doalsty	Due to (or as a	conseque	ence of):				,	/	1	2 . 4
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a		ence of):	irysm				_		> months
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Print	+10	Jay	Jersos.	Sero	tré	disa	005	0	1044955
ó	an an		resulting in death) Last	Due to (or as a	consequ	ence of):		, (, ,					1
68760,	ficate be executed physician and s the burial-transit	edicai		d									
_			IF FEMALE:	To If you system a									
Вох	The law requires that the death certite has been signed by the attending to be 2 should be detached for use a	Physician/M	in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth = 2 4 ☐ Pregnant at t	2 Fetal	death 3	Ectopic pregnancy Other (specify)	1			23	d. Date of delive Month	ery Day Year
P.O.	that the de ad by the detached	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown	unio oi de	atti 5[_	Other (specify) _						
	igned b	by Pt	Part II. Other significant conditions co							23e. Did tob	acco use	contribute to t	he cause of death?
rds	v require been sig should b	ed to	Paroxysi	nal at	Yic	1 4	ibrilla	hon		172/19	s 2 🗆	No 3 ☐ Prot	ably 4 DUnknown
of Vital Records,	law requasi been 2 should	Completed								24a. Was an			psy findings available mpletion of cause of
æ	The la ate ha	E O								perform	ned? ⊠No	death?	2 No
/ita	ysiclan: The is certificate hidirector, page	Be	25. Was case referred to medical examiner?	to amittal.			0.1		of Death (Ch			75	
of	Physi this c	2	1 ☐ Yes 2 No 27. Manner of Death	-lospital: 1 Inpatier 28a. Date of Injury		R/Outpatien 28b. Time of		40140	4-			Other (Specif	iy)
0	ding l h. After funer	tion	1 Natural 5 Pending	(Month, Day	Year)	Injury	28c. Injur Wor	yal k? Yes 2 □ I		Describe ho	w injury c	occurred	
Division	Attence death	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injur	ry - At hor	ne, farm, str			_	_ocation (Str	reet and l	Number or Rura	I Route Number,
ē	s afte	Cert	4 Homicide	building, etc.	. (Specify))	·			City or Town	, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, £	Medical Certification:	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	sician: To the best of iner: On the basis of and manner stat	examination	riedge, death on and/or inv	occurred at the tirestigation, in my c	ne, date an pinion, dea	d place, and o	due to the ca the time, da	use(s) ar ate and pl	nd manner as s lace, and due to	tated. the cause(s)
	To ti To ti comp	Σ	29b. Signature and title of certifier	. 0			29c. Licens					signed (Month,	
	di		Afon.	el ,	m.D.	•	0-	001	4544	+ .	Seg	ot 9,2	005
	10		30. Name and address of person who c	ompleted cause of de	eath (Item	23a) (Type,							21078
	Sta	ite						ノシレイ	75 2	C (5-)	NOC	In 1 I de	21018
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Di	MH 17 Bev 1/2	001				-							

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DOD: 9/4/05

State of Maryland / Department of Health and Mental Hygiens 29770 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 5, 2005 **Physician** ELSIE SCHWARTZSTEIN 11:50 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LUTHERVILLE GENESIS BRIGHTWOOD NURSING HOME BALTIMORE | If Under 24 Hrs. | 8. Date of Birth | Hours | Min. | OCI . 5, 1910 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 ₩ F Director 063-30-4452 94 NY Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "netural", or Iteme 23e or 28a-f show the Medical Exercitive must be notified at Director BALTIMORE 1 X Yes 2 ☐ No MD N/A 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? 2300 CREST ROAD 21209 filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 0. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 X Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LEGAL SECRETARY LAW permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other treumatic event ODG. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be BERMOWITZ TDA RAFALOW PHILIP ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2300 CREST ROAD - BALTIMORE, MD 21209 SHEILA THALER / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BETH DAVID CEMETERY 09/08/2005 * 4 ☐ Donation 5 ☐ Other (Specify) ELMONT, NY 21. Signature of Foneral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Epfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart dilure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Pnysician 20 YEARS ATHEROSCLEROTIC CARDIOVASCULAR DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any loading time districtions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 🗓 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DEMENTIA, COPD, ANEMIA, OSTEOPOROSIS 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 ☐ Yes 2 X No or Attending Physiclen: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 7 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation death, 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) aucre D45432 SEPTEMBER 7, 2005 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21 CROSSROADS DRIVE #400 - OWINGS MILLS, MD 21117 TAMARA S. SOBEL, M.D. 2. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 3 2005 leave It Spark Registrar

State of Maryland / Department of Health and Mental Hygien 2005 29771 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** LEONARD SHULMAN 9 30 PM NORMAN 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examinér BALTIMORE SPRINGHOUSE PIKESVILLE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. | AUG - 4, 1923 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 □ F 82 Yrs. 218-26-2829 MD Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show other traumatic event, the Madical Examiner must be nutified at Director 1 ☐ Yes 2 No BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8911 REISTERSTOWN ROAD 21208 APT. USA Funeral be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 MYes 2 No WWII If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 🔀 No Specify: WHITE ģ Specify: 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) PROPRIETOR JEWELRY STORE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked of HARRY SHULMAN **GELDMAN** MOLLIE Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If item 27 is 7 or other tra HARRIETT SHULMAN / WIFE 8911 REISTERSTOWN ROAD #305 - PIKESVILLE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. BALTIMORE HEBREW CEM. 09/11/2005 REISTERSTOWN, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the discaler or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or rear failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting to death) **Physician** Packinsons deseaso years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, any learning to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner One to for as a nonsectioned of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, signe I be 2 No 3 Probably 4 Unknown 1 Tyes Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 25. Was case referred to predical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Vursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No After the funeral 28a. Date of Injury (Month, Day Year) 27. Mann-1 28c. Injury at Work? Teath 28b. Time of 28d. Describe how injury occurred 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 024121 (Type, Print) 30. Name and address of person who completed cause of death (Item 23 V 21, WEST 31. Date filed (Month, Day, Year) SEP 1 3 2005 32. Registrar's Signature Cost Registrar

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			For State C State Registrar	of Maryland / Depa <i>Cer</i>	artment of Healt tificate of Dea	h and Men th	tal Hygien Reg. N		29772
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Yetta Sawkey	^			Date of Death Month D PTEMBER	^{ay} 10, 2005	3. Time of Death 12:10 P M
	Examin	ėr	4a. Facility Name (If not institution, give street and not 3211 CLARKS LANE #319 5. Social Security Number 6. Sex	umber) 7. Age (In yrs. last birthday)		LTIMORE		c. County of Death	N/A
	Funeral Director		213-26-1986 1 M 2 T F Usual Residence of Decedent	96 Yrs.	Months Days Hou	Min. DE	Date of Birth Month, Day, Yea C.25,190	08	place (State or Foreign ntry) UKRAINE
	a Marylan 8a-f ehow	ctor	10a. State 10b. County N/A	10c. City, Town or Lo		LTIMORE		1	10d. Inside City Limits 1 Yes 2 No
YETTA	s 23e or 2	Funeral Director	3211 CLARKS LANE #319		I	215		Citizen of What Cour	USA
n (0	within 72 hours aftar death with tha Maryland ena. then "naturel", or Items 23e or 28a-f ehow the Modical Exposited from the notified at	by	Armed F	2 🔏 No ive	Was Decedent of Hispanic f Yes, specify Cuban, Mex 1 ☐ Yes 2 X No Spec		Yes or No- n, etc.)	14. Race - Americ Black, White, Specify:	
SONIKER, 21215-0036	ifiled within 72 h I Hygiena. other then "natu	Completed	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College 5+	(Give	dent's Usual Occupation kind of work done during r DO NOT use retired) HER	most of working		Kind of Business/In	dustry
	\$ 5 5	Be	17. Father's Name (First, Middle, Last)		18. M	lother's Name (Fir			CTODAY
Maryland	d 2 should be th and Mental 7 le marked o traumatic eve	Ը	PINCUS 19a. Informant's Name/Relationship (Type, Print)		NBERG FA	NNIE Imber or Rural Ro	ute Number, City	or Town, State, Zip	STOPAK Code)
	nd 2 IIth a 27 Ic		SHIRLEY KLUPT / DAUGHT		CHERRY VALLE	7		RSTOWN, M	
Baltimore,	Pagas 1 au nent of Hea int: If item iry or othe		20a. Method of Disposition 1 🛣 Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	1 State	sition (Name of natory or other place) HAIM CEMETER	Date 9/11/2		Location - City or To	
Balti	permit. Pagas Department of Important: If it any injury or o		21. Signature of Euperal Service Licensee	22	2. Name and Address of Fa	acility SOL L	EVINSON	& BROS.,	INC.
	Pnysician /Medical	6	23a. Part1. Exter the disease, or complications that shock or hear failure. List only one cause on Immediate Cause (Final disease or condition resulting in death)	ielanoma	er the mode of dying, such	h as cardiac or res	piratory arrest,		Approximate Interval Between Onset and Death
	Examiner			o (or as a consequence of):					
8	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of hijury that initiated events c.	o (or as a consequence of):					
,09289	icate be executed physician and s the buriat-transit	edicai Exa	resulting in death) Last Due to	o (or as a consequence of);					
P.O. Box 6	i on a	Physician/Me	in the past 12 months?	gnant at time of death 5	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
	w requires that been signad b should be deta	by	Part II. Other significant conditions contributing to	death but not resulting in the u	nderlying cause given in P	art I.		o use contribute to the	he cause of death?
Division of Vital Becords.		Completed					24a. Was an autopsy performed?	prior to co death?	opsy findings available impletion of cause of
Vita	sicien: Th certificate iractor, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 Ho Hospital: 1	Inpatient 2 ER/Outpatier	24	Place of Death (Ch		6 ☐Other (Specil	6.1
nof	Attending Physicien: r death. ector: After this certific by the funeral diractor.	\vdash		e of Injury 28b. Time o Injury Injury	f 28c. Injury at Work?	28d.	Describe how in		y)
Divisio	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral diractor,	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined buil	ce of Injury - At home, farm, str ding, etc. (Specify)	M 1 ☐ Yes 2	28f. l	Location (Street City or Town, Sta	and Number or Rura ate)	al Route Number,
	e Hospital 124 hours a 6 Funeral I	Medical C	29a. Certifier (Check only one) Certifying Physician: To the and ma	ne best of my knowledge, deat basis of examination and/or in inner stated.	h occurred at the time, dativestigation, in my opinion,	e and place, and death occurred a	due to the cause t the time, date a	(s) and manner as s ind place, and due to	stated. o the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of celtifier Thousand the state of the state		29c. License numb	ber	29d. C	Date signed (Month,	Day, Year)
_	4			use of death (Item 23a) (Type, 838 GV FMPTV	Print Ball	wur M	D 313	, 908,	
	Sta Regist		31. Date filed (Month, Day, Year) SEP 1 3 2005	Regultrar's Signature	Sporte				

State of Maryland / Department of Health and Mental Hygiene 2005 29773 1 - State Registre Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** George A. Schultz September 8, 2005 9:50A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A 2217 Lake Avenue Baltimore If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2√2 F 84 214-16-3320 **Director** 8/23/1921 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show 7 is marked other than "neturel", or items 23e or 28e-f shot treumatic event, the Middical Extendition at Baltimore N/A XXYes 2 □ No Md Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 21213 2217 Lake Avenue U.S.a. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3√ Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry C&P Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ent: If item 27 is marked other than 'ury or other treumatic event, Ite Mi. Elementary/Secondary (0-12) College (1-4or 5+) 12 Lineman & repairman Telephone Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Margart C. Butler George A. Schultz Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2217 Lake Avenue Baltimore, Maryland 21213 19a. Informant's Name/Relationship (Type, Print) Suzanne Preis 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □xBurial 2 □ Cremation 3 □ Removal from State permit. Page Department o Importent: If any njury or once. • 4 □ Donation 5 □ Other (Specify) Most Holy Redeemer 9/13/05 Baltimore, Maryland 21. Signature of Fungral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 6415 Belair Road Baltimore, maryland 21206 TURA 23a Partf. Enter the disease, or complications that cause 1 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician weck /Medical Due to (or as a **Examiner** Sequentially list conditions, any, loading to in rediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown onditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No this certificate has autopsy 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 esidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 XNo s after death.
I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled 24 hours a Medical 29a. Certifier 🗽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) HEND NG Sept 12, 2005 Ma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) New and SchWARTEMA 31. Date filed (Month, Day, Year) State Registrar

			State of Maryland / Department of Health and N State of Maryland / Department of Health and N Pegistrar Certificate of Death		ene2005	29774
	Physici /Medio		Decedent's Name (First, Middle, Last) FRANCES M. TWELE	2. Date of Death Septembe	r ^{Day} 9. 2005	3. Time of Death 10:30 a.M
	Examin		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 3700 North Charles Street, Apt. 206 Baltimore		4c. County of Death N/A	
	Funeral Director		5. Social Security Number 6. Sex 1 Months 1 Mont	8. Date of Birth (Month, Day, You 12-02-19	ear) 9. Birthp Court 49 MA	lace (State or Foreign try) RYLAND
	ylend		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			0d. Inside City Limits
	the Mar	Director	MD N/A BALTIMORE CITY 10e. Street and Number 10f. Zip Code	10a	. Citizen of What Cour	Yes 2□No
	ath with		3700 NORTH CHARLES STREET,#206 21218		U. S. A	•
5-0036	ers after de	by Funeral	11. Marital Status 1 □ Never Married 12 □ Married 13. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes ☐ Yes ☐ Yes ☐ Yes, specify Cuban, Mexican, Puerto 14 □ Yes ☐	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: W	an Indian, etc. -{ITE
21215-0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mentel Hygiene. Important: if item 271e marked other than "naturel", or items 23e or 28e-f ehow early flury or other traumatic event, the Medical Event art must be notified at ange.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 YEARS 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) SECRETARY	ing	b. Kind of Business/Ind	dustry NS UNIVERSI7
Maryland 2	uld be filed Mentel Hygi Irked other Itic event, I	To Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, Ma ERINE L	iden Sumame) AWLOR	
Man	nd 2 shoulth and 27 le mu		19a. Informant's Name/Relationship (Type, Print) CHRISTOPHER TWELE (SON) 19b. Mailing Address (Street and Number or Runt) 5 WIMPOLE COURT, COCKEY			
Baltimore,	Pages 1 a nent of Hee nt: if Item iry or othe			Date 20	c. Location - City or To	wn, State
Balti	permit. Depertrimit imports eny inju		21. Signature of Funeral Service Licensee (R.G.RUTH) RUCK TOWSON FUNERAL	_ HOME,ING	1050 YO C. TOWSON	ORK ROAD MD.21204
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line and and brug(Citalopram of the condition of condition resulting in death) Due to (or as a consequence of):	or respiratory arrest and Oxyco	done)	Approximate Interval Between Onset and Death
68760,	iicate be executed physicien and s the burial-transit	al Examiner	Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			
P.O. Box 687	The law requires thet the death certificate to has been signed by the attending physogge 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \ \text{Yes} \ 2 \ \text{No} \\ 2\text{Vinknown} \ \text{Vinknown} \ Vink		23d. Date of delive Month	ry Day Year
rds, P	quires thet in signed b uld be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to th	e cause of death? ably 4 □Unknown
Division of Vital Records,	i: The law requir icate has been si r. page 2 should	Completed		24a. Was an autopsy performed	d? prior to cor death?	osy findings available npletion of cause of 2 No
f Vit	Physician: The l this certificate ha al director, page	To Be	examiner/	h <i>(Check only one)</i> ome 5 ☐ Residenc	e 6 💆 Other (Specify	At scene
ion o	ling l		27. Manner of Death 1 \[\text{Natural} \] 5 \[\text{Pending} \] Pending 2 \[\text{Accident} \] Accident 28a. Date of Injury 48b. Time of Work? 5 \[\text{Pending} \] Polymonth (Morth, Day Year) 5 \[\text{Pending} \] 5 \[\text{Pending} \] 1 \[\text{Yes} \] 28b. Time of \[\text{Work?} \] 1 \[\text{Yes} \] 28c. Injury at \[\text{Work?} \] 1 \[\text{Yes} \] 28c. Injury at \[\text{Work?} \] 1 \[\text{Yes} \] 28c. Injury at \[\text{Work?} \]	28d. Describe how	injury occurred	unk
Divis	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	Certification:	3 ☐ Suicide 4 ☐ Homicide 1	28f. Location (Stree City or Town, S Baltimore		Charles St.
	Hospi 24 hours Fune Hetely fill	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the caus red at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
)	To ti within To ti comp	Me	29b. Signature and title of certifier Wallante Med Scull YM 29c. License number OCME		Date signed (Month, eptember 10	
	OLAS		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street	Baltimo	re, Maryla	nd 21201
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature			

		1 - State Unpend Item 2 1. Decedent's Name (First, Middle, Las		per me	fifficate of D	eath	Reg.	No.	3. Time of Death
Physicia /Medic	al	Earl	J.	Т	homas	tion of Doo	Septem	per 8, Year	O5 4:31 F
Examin	er	4a. Facility Name (If not institution, give Johns Hopkins Ho			4b. City, Town, or L Baltimor		tn	4c. County of Dea	tn
Funeral Director		210-70-3377	ex 7. Age (in y	rs. last birthday) Yrs.		If Under 24 Hrs Hours Min		9. Bir 60	thplace (State or Fore cuntry) Md.
MO H		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation			<u> </u>	10d. Inside City Lin
natural', or items 23a or 28a-f ehow itsel Exercine must be notified at	Director	Md. NA		Balt	imore				XXYes 2□
a or 2		10e. Street and Number 129 Montford	λιζοπιιο		10f. Zip Code	224	10g.	Citizen of What Co	ountry?
Items 23	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces?	n U.S. 13. V	Vas Decedent of Hisp Yes, specify Cuban,		Specify Yes or No- rto Rican, etc.)	USA 14. Race - Ame Black, Whit	
tural', or	ρ	**XWidowed 4 Divorced 15. Decedent's Ed	1 ☐ Yes X No If Yes, Give Year or Dates:		☐ Yes 2X No	Specify:	160	Specify: B	lack
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and e m		19a. Informant's Name/Relationship (Reginald Thoma	• • •	19b. Mailin	g Address (Street and	d Number or R	ural Route Number, C , Baltim	ity or Town, State, a	Zip Code) Ant
teeling her		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	b. Place of Dispo cemetery, cren	sition (Name of natory or other place)		Date 200	. Location - City or	Town, State
Department of Himportant: If Ite any Injury or of once.		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen		It. Zio	n Cem. Name and Address	1		Lansdow	
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ste has bean signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons						
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bean signed b should be deta	ρ	Part II. Other significant conditions of	ontributing to death but not	resulting in the ur	nderlying cause given	in Part I.	23e. Did tobac 1 ☐ Yes		othe cause of death obably 4 Dunkno
	Completed						24a. Was an autopsy performed 1 Ves 2	? death?	utopsy findings availa completion of cause 2 No
this certific	o Be	25. Was case relerred to medical examiner? 1 X Yes 2 □ No	Hospital:	XXER/Outpatien	Othor		ath (Check only one) Home 5 Residence	e 6 ∏Other (Soe	cify)
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E 2 E	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 M Could not be determined	28e. Place of Injury - A building, etc. (Spe Home	it home, farm, streecify)	eet, lactory, office		281. Location (Stree City or Town, S Baltimore		Montford
24 hours a e Funerel (letely filled	edicai	Check only one)	nysician. To the best of my had niner: On the basis of exame and manner stated.	knowledge, death sination and/or inv	restigation, in my opin	, date and place nion, death occ	e, and due to the caus urred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
22 H	. •		and manner stated.		1 00 1		104	5	
To the Funeral	Me	29b. Signature and title of certifier	$\kappa \cap$		O.C.M. I	iumber ∃.		Date signed (Monti September	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 1 1 5 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** September ^ Q homas 9AM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Reh Baltimore coint JUIGIN-If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 💢 F 219-20-5368 Yrs. Director 94 21 MD Usual Residence of Decedent filed withIn 72 hours after deeth with the Maryland 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Modical Examiner must be notified at Completed by Funeral Director 1 □X es 2 □ No MD Baltimore NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2525 West Belvedere Ave 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Yes 27 No f Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If Item 27 Is marked other tt any Injury or other traumatic event, ILIS once. 12th grade Homemaker House na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown Georg Palmer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21208 19a. Informant's Name/Relationship (Type, Print) Michele Loewenthal-Guardian 1777 Reisterstown Road, Pikesville, 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) Date 20c. Location - City or Town, State M Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 9/14/05 Baltimore, Md Mt. Zion of Funeral Service Licensee 22. Name and Address of Facility March F/H West 3a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between I mediate Cause (Final disease or condition resulting in death) Onset and Death thero sclerution Paysician /Medical Due to (or as a consequence of): **Examiner** to (cras a consequence of): Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner and i-transit The law requires that the death certificate be executed Due to (or as a consequence of): attending physicien a for use as the burial-Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 22 No 1 TYes Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No Division of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After t Certification: 5 Pending investigation 1 Natural 2 Accident death. 1 ☐ Yes 2 ☐ No Director: 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Amostun N Mace m September 15 503 30. Name and address of person who completed cause of death (Item 23a) (Type, Print),

DHMH 17 Rev 1/2001

State Registrar 501

32. Registrar's Signature

HEEM

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31. Date filed (Month, Day, Year) SEP 1 3

Dolphin st Baltimore,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Department of Health Certificate of Death		entai Hyg Re	g. No. 20	05	29777
	Physiciar /Medica		1. Decedent's Name (First, Middle, Last) Mary Elizabeth Troy		2. Date of Death Month Repfember	Dev	Year DOS	3. Time of Death 7:00P77
)	Examine			Town, or Local	ation of Death	4c. County	of Death	
	Funeral Director				B. Date of Birth (Month, Day, Nov. 26		9. Birthpi Coun Ken	ace (State or Foreign iry) Lucky
	Anyland show	Jo.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10c. Maryland N/A Baltimore					od. Inside City Limits
	3a or 28a-	II Direct	10e. Street and Number 10f. Zip Code 2522 Elm Avenue 21211		10	og. Citizen of V	What Coun	try?
020	ed within 72 hours efter death with the Maryland ygiene. In the "naturel", or items 23a or 28a-f show it, the Medical Examiner must be notified at	by Funera	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 2 Married 1 Never Married 2 Married 2 Married 1 Never Married 2 Married 2 Married 1 Never Married 2 Married 2 Married 1 Never Married 2 Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 2 Married 1 Never Married 2		ify Yes or No- ican, etc.)		e - Americ ck, White, c	
21215-0020	permit. Peges 1 and 2 should be filed within 72 hours Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "naturel", any injury or other traumatic event, the Medical Exp DDCB.	ompiered	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown 16a. Decedent's Usual Occupation (Give kind of work done during modifie. DO NOT use retired) Factory Worker	ost of working	9	Spice	c Comp	
	d be filed ed other sevent,	9	17. Father's Name (First, Middle, Last) 18. Mott		First, Middle, M E11en		•	
Maryland	id 2 should the Ith end Ment (7 is marked traumatic 4	=	19a. Informant's Name/Relationship (Type, Print) Nancy Cevallos Daughter 19b. Mailing Address (Street and Num. 3522 Elm Avenue	nber or Rural	Route Number,	City or Town,	State, Zip	Code) 21211
Baltimore,	Peges 1 er ent of Hee nt: If Item 2 ry or other		20a. Method of Disposition **CXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memori		Date 2	20c. Location -	City or To	
Balti	permit. Depertminportal any inju		21. Signature of Funeral Service Licensee Burgee-Henss 3631 Falls R	cility S-Seitz	z Funera	al Home	, Inc	21211
-	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line.	as cardiac or	respiratory arre	st,	1	Approximate Interval Between Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) End - Stage Algherines is a Due to (or as a consequence of):	lisear	e e		1 1	lears.
Box 68760,	oentificate be executed and inding physician and use as the buriel-trensit	- 1	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last b					
-	e death the ette	3 2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	rt I.	23b. Did tol	Dacco USB CO	etfibute to	the cause of death?
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al B	ysician: The law is certificate hes b director, page 2 s		Utrial fibrillation	(D.A)	1 □ Ye		1□	Yes 2□ No
F VII	Physician: rthis certific arel director,		examiner?		<i>Check only one</i> e 5 □ Reside		er (Specify)
o uo	After the funeral	-	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 No. 3	28	d. Describe ho			
Division	tal or Attending Pins offer death. It bluector: After the in by the funere Certification:	Ci illica	2 Accident anvestigation 3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		If. Location (Str. City or Town,		er or Rural	Route Number,
	ne Hospi n 24 hou ne Funer pletely fil	Salca B	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date a construction of the basis of examination and/or investigation, in my opinion, deand manner stated.	and place, an eath occurred	d due to the ca l at the time, da	use(s) and ma te and place,	nner as sta and due to	ated. the cause(s)
	within To the comp		29b. Signature and title of certifier M. Babelle Pac Gregor D 29c. License number D13657			enterné		
	30	7	M Habelle Tax Gregor TD D13657 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1. ISABELLE THE REGOR, 700 W 40 th STREET, B	ALTI	TORE,	170 21	211	
	State Registrar		31. Date filed (Month, Day, Year) SEP 1 3 2005 32. Hegistrar's Signatura					

State of Maryland / Department of Health and Mental Hygiene, For State Registrar 29778 Reg. No. Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month Philip 10:08 A M 09 09 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Year If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Days Yrs. Director 77 MD 219-22-6092 Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, It a Marical Examiner investible and once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD Anne Arundel Linthicum 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 N. Longcross Road 21090 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Warehouseman Warehouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname. James Tacka Christine Antionette Ogar 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary E. Tacka / wife 101 N. Longcross Road, Linthicum, MD 21090 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sept. 13, 2005 Glen Haven Mem. Park Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, P.A. mak f. M01357 I Second Ave Sw, Glen Burnie, MD 21061 23a. Part1. The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Aspiration Prumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, they leading to infried at cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physicien end as the burial-trans Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. Physician/Medicai ettending p IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 2 No ed by the 9 Unknown 9 Unknown been signed t should be deta Part II., Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? has certificate 1 ☐ Yes 2 No 1□ Yes 2 No To the Hospitei or Attending Physicien: 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 X ER/Outpatient 3 DOA this After this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 Natural Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a. Certifier (Check only one) 29b. Signature and titl 29d. Date signed (Month, Day, Year) D38958 MA D who completed cause of death (Item 23a) (Type, Print) hway Sw Clen Burnu MD 21061 208 eel Crain 31. Date fied (Month, Day, (Year) State 2005 Registrar

			1 - State Registrar 1. Decedent's Name (First, Middle, Last		Ce	rtificate of	Death	2. Date of Dea		3. Time of Death
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,	Examin		4a. Facility Name (If not institution, give 14202 Valleyfield			4b. City, Town, o	r Location of Death Spring		4c. County of De	
	Funeral Director		5. Social Security Number 6. Se 147-12-7687 Usual Residence of Decedent	x 7. Age (] M 2⊠F	(In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Jan. 2	9. Bi 7. 1925 Nev	rthplace (State or Foreign Sountry) V Jersey
	anyland ebow	ō	10a. State 10b. County		IOc. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🔀 No
:	or 28a-f	Director	Maryland Montgome		Silver Sp	10f. Zip Code			10g. Citizen of What C	
3	be lied within /z nours after death with the Maryland ital Hygiene. Ital Hygiene. do other then "natural", or itema 23a or 28a-f ehow event, if a Madical Examinar must be notified at	by Funeral	14202 Valleyfield 11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Drive, #3 12. Was Decedent Ev Armed Forces? 1 Yes 2 WNo If Yes, Give Year or Dates:		20906 Was Decedent of H If Yes, specify Cubin	dispanic Origin? (Spi an, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	Specify:	ierican Indian,
7	within 72 ho jiene. rthen "natur It's Medical I	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 1 2	cation le <i>completed)</i> College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	eation during most of works d)	ing	16b. Kind of Busines:	s/Industry
	snould be filed and Mental Hygi s marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) William C. Hoffm	an			Eve Tec	leger	Maiden Surname)	
	permit. Pages 1 and 2 should begarment of Health and Machanit if item 27 is marker any injury or other traumatic e once.		19a. Informant's Name/Relationship (T) Patricia A. Corve 20a. Method of Disposition 1	11i/Daught Removal from State Entombment	er 1420 20b. Place of Dispo cometory, cran Gate of Mausoleu	2 Valleyf sition (Name of natory or other place Heaven im . Name and Addre ockville,	Sield Drivers Sept 13, ss of Facility Rob	re, #3, ember 2005 ert A.	20c. Location - City o Silver Sp Pumphrey F Montgomery	r Town, State
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	g physician and as the burial-transit	al Examiner	Sequentially list conditions, Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		or sequence of					
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	effer death. I Director: After din by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, str (Specify)			28f. Location (Si City or Town	treet and Number or R n, State)	ural Route Number,
914000	within 24 hours e	Medical C	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examination)	sician: To the best of r ner: On the basis of ex and manner states	camination and/or inv	occurred at the time vestigation, in my of	ne, date and place, a pinion, death occurre	and due to the cared at the time, d	ause(s) and manner a ate and place, and due	s stated. e to the cause(s)
,	within 2 To the comple	Z	29b. Signature and title of certifier	6		29c. License			9d. Date signed (Moni	
3-	N 4		30. Name and address of person who construction Stephen Vaccarezz 31. Date filed (Month, Day, Year) SEP 1			Print)				

		ĺ	For State Registrar	State of Ma	arylanu .	Cei	rtificate of	neaith an Death	u Mentai n	Reg. No.	2005	29780
	Physici	an	Decedent's Name (First, Middle, La						2. Date of D	Day	Year	3. Time of Death
	/Medic	al		Bobbie Joy	ce Tay	lor			Septem	ber 8	2005	5:30 AM
	Examin	er	4a. Fecility Name (If not institution, given Holy Cross Hospi				4b. City, Town, o	er Spri			County of Death	
	Funeral		5. Social Security Number 6. S		e (In yrs. last	birthday)	If Under 1 Year	If Under 24 l	Irs. 8 Date of B	irth	ontgome:	L y place (State or Foreig ntry)
	Director		200-44-0738	□M 23xF	73	Yrs.	Months Days	Hours M	Jan. 1	8, Year)	32 A1	abama
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation		<u> </u>			10d. Inside City Limits
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	th the or 28,	Oirec	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Cou	ntry?
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ary	shou and M a mar umat	-	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address (Street	and Number or	Rural Route Num	ber, City or	r Town, State, Zij	Code)
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CPM 05-06124 Christoph

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State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) SEPTEMBER Da Year 2:15 PM **Physician** WALDMAN EDWARD 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CENTER. RANDALLSTOWN BALTIMORE: NORTHWEST HOSPITAL If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV 27, 1929 If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Maryland 1**X**M 2□F Yrs. Director 217-24-2746 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show treumatic event. The Maxical Examiner must be multiled at ¥ Yes 2 □ No Funeral Director Maryland n/a Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21230 United States 3023 Janice Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after 1X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 7 h and Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 11 Paint Maker Paint 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Alberta R. Breighner Adolf F. Waldman permit. Pages 1 and 2 shc.
Department of Health and M.
Importent: If Item 27 is markany injury or other 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3023 Janice Avenue, Baltimore, Maryland 21230 Dorothy Waldman / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State Meadowridge Mem. Park 9/13/05 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Ligenses 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS-Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Winknown ACUTE RENAL FAILURE : CORONARY ARTERY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 Yes certificate Hospitel or Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after d 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 24 29d. Date signed (Month, Day, Year)
SEPTEMBER 9 29c. License number 3 · 29b. Signature and title dertifier SEPTEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTH WEST COVER AVYER AKALLI HARISH. CENTER 32. Registrar's Signature 31. Date filed (Month, Day, Year) SEP 1 3 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 2005 20

			1 - State Registrar		,		tificate c		th	iona n	Reg. i		UD	29/03
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			Charles Co. Nu				La Pl					Char	rles	
	Funeral Director		5. Social Security Number 175–14–5494	5. Sex 7. Age 1 M 2	e (In yrs. ias 84	st birthday) _ Yrs.	If Under 1 Ye Months Da		der 24 Hrs. s Min.	8. Date of B (Month, D	av. Yea	ar)	Count	ace (State or Foreign
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	er de	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?		13. W	as Decedent of Yes, specify C	of Hispanic (Juban, Mexic	Origin? (Spican, Puerto	ecify Yes or N Rican, etc.)	0-		e - America k, White, e	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural", or itama 23a or 28a-1 show any figury or other traumatic event, the Madicial Expiritive reliable notified at ODGe.	by F	1 ☐ Never Married 2 ☐ Marrie 3 🔀 Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 📉 N If Yes, Give Year or Dates:	10	1	☐ Yes 2🌠 f	No Speci	ity:			Specify	,.	
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G,	Physician		Immediate Cause (Final disease or condition	Carol	mova	soule	as A	C C 1 1	Open >	L				Interval Between Onset and Death
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Ö	w require been sig should b	etec						-		10	Yes 2	No :	3 Probab	oly 4 Unknown
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	g Phys er this ieral di	⊢ ∤	27. Manner of Death	28a. Date of Injury (Month, Day		b. Time of	28c. Inj	ury at		e 5 ☐ Resided Bd. Describe				
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	o the ithin 2 o the omple	Mec	29b. Signature and title of certifier	and manner state	ed/			nse number						
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	,,		30. Name and address of person wh	o completed cause of dea	th (Item 23	ay (Type, Pri	int)	105	211	7		1 11/	03	
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		1	State of Maryland / Dep	ertificate of Death		iene eg. No. 2005	29784
	ysicia ledica	n	1. Decedent's Name (First, Middle, Last) Donald P. Wright		2. Date of Deat Month Sept.	Day Year 10 2005	3. Time of Death 1:50р м
1	amine		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deatl	1
			801 MAce Ave.	Essex		Baltimor	
Fund Direct			5. Social Security Number 212-32-5561 6. Sex 1	Months Days Hours Min.	March March		nplace (State or Foreign Intry) Tyland
and	-	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits
Maryl	a de	ğ	MD Baltimore Esse	2X			1 ☐ Yes 2X No
r 28e	not	Lec	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Co	untry?
h with	2	a D	801 Mace Ave.	21221		USA	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Maryland Department of Health and Mental Plygiene. Important: if item 27 is marked other then "naturel", or items 23a or 28e-f show	xaminer m	by Fur	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married Forces? 1 Never Married 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spuff Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
21215-0036 3d within 72 hours at giene. er then "naturel", or	9 Medical I	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) Nortgage Banker	ing	16b. Kind of Business/I	
tygier the	표	ပိ	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First Middle II	Maiden Sumame)	
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Mar Ind 2 sh alth and 27 is m	ar traum			ling Address <i>(Street and Number or Rure</i> 01 Mace Ave. Bal		•	
Baltimore, Dermit. Pages 1 a Department of Her	iry or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)			20c. Location - City or Baltimore	
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Vital F sicien: Th certiticate	funeral director, page	Be	25. Was case referred to medical examiner?	26. Place of Death	h (Check only on	Θ)	
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Div To the Hospitel or within 24 hours afte To the Funerel Dir	completely tilled in by	edical C	29a. Certifler (Check only one) 1 Certifying Physician: To the best of my knowledge, dec 2 Medical Examiner: On the basis of examination and/or and manner stated.				
To the Within To the	compl	Me	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Month	, Day, Year)
)			Kin S Wy ms	D41614	+ <	Scaterdar	15,5002
	6		30. Name and address of person who completed cause of death (Item 23a) (Type Hau Haule 49.20 Cerus	Print) (2 \ 0 V	altimo	w IMD	21236
Re	Sta		31. Date filed (Month, Day, Year) SEP 1 3 2005	Goarles	- 6 1 Mags		0.0-20
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700	- Funeral Director		5. Social Security Number 213-28-3734 Usual Residence of Decedent	6. Se	х М Х ДГ	ge (In yrs. las	Yrs.		Days			ate of Bi Wonth, D	ay, Year)	9. 8	lirthplace (State Country) MD	or Foreign
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Ball	permit. Pag Department Important: I any injury o		21. Signature of Funeral Serv	ice Licens	Edmo	net	M	Name and arch 300 W	F/H	Wes	t ve, E	alt	imor	e, Mo	212	15
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O. Box	that the death certificated by the attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	2	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal d	eath 3	Ectopic pre Other (spe					2	23d. Date of d Month	lelivery Day	Year
Records, P.	sign d be	by	Part II. Other significant cond	ditions co	ntributing to death t	Λ	ing in the u		use given	in Part I.			tobacco u		to the cause of	
õ	w requ	olete	Aure	ر کی	Sinn			_			_ [:	24a. Was	s an	24b. Were	autopsy finding	s available
æ	The tav	Completed	11		, , .						_	auto perf	ormed2 2 Doo	death'	o completion of ? es 2□ No	cause of
Vital		BeC	25. Was case referred to med	ical						26. Place o	f Death (Ch		~	10,1	33 2 140	
of V		ToE	examiner? 1 XYes 2 □ No	H	Hospital: 1 🗌 Inpati	ent 2	NOutpatier	t 3 DOA	Other	4 🗆 Nurs	ing Home	5 🗌 Res	idence 6	6 □Other (Sp	pecify)	
u o	ing Pl		27. Manner of Death 1 Matural 5 ☐ Per	nding	28a. Date of Inju (Month, Da	ury 2 uy Year) 2	8b. Time o Injury		lc. Injury a Work?			Describe	how injur	y occurred		
sio	tendi leath. tor: A the fu	cati	2 Accident inv	estigation uld not be				М		es 2 No						
Division	tal or At is after of al Direct ed in by	Certification:		benime	28e. Place of In building, e	jury - At hom tc. <i>(Specify)</i>	e, tarm, str	eet, factory,	office		28f. L	ocation of the control of the contro	(Street and own, State)	d Number or ()	Rural Route Nu	mber,
	To the Hospital or Attending Phys within 24 hours after death. To the Funaral Director: After this completely filled in by the funeral di	edicai	29a. Certifier 1 Certi (Check only 2 Madi one)	fying Phy cal Exami	sician: To the best ner: On the basis of and manner st	ol my knowl of examinatio ated.	edge, deat n and/or in	n occurred at vestigation, i	it the time in my opin	e, date and p nion, death	place, and o occurred at	lue to the the time,	cause(s) date and	and manner I place, and di	as stated. ue to the cause	(s)
	To t To t com	×	29b. Signature and title of cer	tifies	n. ()	دا طله		29c.	License		. 4 f		29d. Dat	e signed (Mo	nth. Dey, Year)	
1	2		30. Name and address of pers	ion who c	ompleted cause of	death (Item 2	3a) (Type,	Print)		06156	. β	. [3-5	44.40	1110	21279	
9			V MA	1 1-	DWHIG.	J 10	710	UH		アハア	\sim D	イン	APIR	/ [U]	ノノレーへ	
	Sta Registr		31. Date filed (Month, Day, Ye SEP		32. Ré gisti	rar's Signatur	re	CANEL	, , ,						-	

			State of Maryland / Department of Health and Mental Hygiene 1 - Stete Registrer Certificate of Death Reg. No. 2 0 0 5												20706			
Physician				Decedent's Name (First, Middle, Last		Robert E. Lee Weinberg, Sr						2. Date of De Month	ath Da	Z U (ナ フ Year カラ	3-Time of Death		
		/Medic Examin		4a. Facility Name (If not institution, give		4b. City, 7	Location o	of Death	9 10 4c. County of Balto			f Death	5:00 a. M					
		Funeral		Stella Maris Towson 5. Social Security Number 6. Sex 7. Age (In yrs. las			at birthday) Yrs.	If Under	OWSO 1 Year Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da 5-8-	th Ly, Year		9. Birthplace (State or Foreign Country) Md			
		Director pg ≱		218-48-3643 Usual Residence of Decedent 10a. State 10b. County			Town or Lo	cation				J-0-	1347		1	10d. Inside City Limits		
		Ba-f sho	Director	Md N/									1 X Yes 2 □ No					
		with th	Dir	10e. Street and Number 10f. Zip Code 21215										itizen of Wi	hat Coul	ntry?		
5:00 а.ш.	5-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "neturel", or Itams 23a or 28a-f show ant, the Modical Examirer is ust be resilfed at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:						14. Race - American Indian, Black, White, etc. Specify: Black						
5 5:	1215-0		Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Regional Supervisor									nd of Business/Industry Using Authority					
2005	d 2	Hygie other t	Be Co	12th grade 17. Father's Name (First, Middle, Last)	4 years				Jupe		_	(First, Middle	, Maidei	n Sumame)			
10,	ylan		ToB	James Weinberg Frances Handy														
~	Maryland 2121			19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernadette Weinberg - Wife 3821 Pall Mall Road Balto, Md 21215														
SEPTEMBER				20a. Method of Disposition		20b. Plac	ce of Dispo	sition (Nam	e of			ate ate		_ocation - C	City or To	own, State		
PTE	altimore,			1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Dopation 5 ☐ Other (Specify)		King	Memo					-2005			sto	vn, Md		
SE	Bal			21. Signature of Funeral Service Licens	. Thomp	por	<u> </u>		43	300	Wabas		nue	est Balto	, Mo	1 21215		
_				23a. Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death														
				Immediate Cause (Final disease or condition resulting in death)	a. LUNG CANO		nce of):				-			-				
				Sequentially list conditions,	b													
			Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	is a consequence of):													
				that initiated events resulting in death) Last	Due to (or as a consequence of):													
-		artificat ing phy e as th	Medi	IF FEMALE:		,												
	.O. Box	or Attending Phyeicien: The law requires that the sifter death. Diractor: Atter this certificate has been signed by the in by the funeral director, page 2 should be detached in by the funeral director.	by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ths?									23d. Date of delivery Month Day Year				
WEINBERG	ords, P			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the														
	al Records,		Completed									24a. Was auto perfo 1 Yes		de	eath?	opsy findings available mpletion of cause of		
LEE	Vita		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital:	nt 2∏ F	B/Outpatien	at 3□ DO	Δ Oth ε	nc.		(Check only o		6 To l Other	r (Snacil	HOCDTOR		
Ħ	on of		tion: To										W HOSPICE					
	Division		Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offi building, etc. (Specify)										Number or Rural Route Number,				
	-	e Hospitel 124 hours a e Funerel	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.											tated. the cause(s)			
ø		To the within 2 To the I		29b. Signature and title of certifier				29c	_	number	21		29d. Da	() /		Day, Year)		
		45		30. Name and address of person who of DR. TARIQ MAHMOO								MD 210) 0 2		7			
		State		31. Date filed (Month, Day, Year)	an Diameter	de Cieres				- 11101	OI19	IW 210	J					
	*	Registr	ar	SEP 1 3 2	005 32. augistra	Be fle	1 /2/3	Car September										

		•	For State Registrar		State of Ma	ryland			nt of He <i>te of D</i>		Mentai	Hygie Reg.		105	29	78	
		Decedent's Name (First, Middle, Last)								of Death				Death			
	Physician Francis M. Wynn, Jr.										th t.	10 2005 1:17 A					
1	/Medic Examin	ledical								ocation of Deat		4c. County of Death					
	Exami	Ŭ,	219 Daw	son Dr.		C	ockey	sville		Baltimore							
	Funeral		5. Social Security N	lumber 6. Se		(In yrs. la	ast birthday)	If Unde	er 1 Year	lf Under 24 Hrs	8. Date	of Birth oth, Day, Ye			Birthplace (State or Foreign Country)		
п	Director		577-38-1	1567	ZM 2□F	74	Yrs.	Months	onths Days Hours Min.			16 1					
	<u> </u>		Usual Residence of														
	how		10a. State	10b. County	10c. City, Town or Location						10d. Inside City						
	B Ma	cto	MD Baltimore Cockeysville						e						1 ☐ Yes 2 No		
	or 28	lre	10e. Street and Nur	mber	10f. Zip Code						10g.	hat Cour	ntry?				
	23a d	ai	219 Daw	son Dr.	21030							US	A				
	ama arma	Funeral Director	11. Marital Status		I Yes 2 No If Yes, Give Year or Dates: Education 16a. Decedent			Was Dece	as Decedent of Hispanic Origin? (Specify Yes Yes, specify Cuban, Mexican, Puerto Rican, e			(es or No-), etc.) 14. Race - Am Black, Wh					
21215-0036	is 1 and 2 should be filed within 72 hours after deeth with the Maryland of Health and Mental Hygiene. Rem 27 is marked other than "natural", or itama 23s or 28s-f show other traumatic event, the Madical Examiner must be notified at	by	1 Never Marri 3 Widowed	ied 2 Married 4 Divorced				1□ Yes		Specify:		Specify: white					
Ŏ	2 ho	Completed	(0	15. Decedent's Edu				dent's Usual Occupation				161	b. Kind of Business/Industry				
21.5	hin 7	ple	Elementary/Seco	ondary (0-12)	College (1-4or 5	(Give kind of work done during m life. DO NOT use retired)					rking						
21	d wit giene er tha	no.	12		n/a	-	Auto Sales Manager						Aut	Auto			
	othy othy	Be (17. Father's Name	(First, Middle, Last)					1	8. Mother's Nar	m <i>e (First, I</i>	viddle, Mai	dle, Maiden Sumame)				
<u>a</u>	Aentz Aentz rked	ToE	Francis M. Wynn, Sr. Marea Fuhrmann														
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than ", iraumatic event, the Mac		19a. Informant's Na	ame/Relationship (T	ype, Print)	ng Addres	ss (Street and	d Number or Ru	ural Route	Number, C	ımber, City or Town, State, Zip Code)						
	1 and 2 Health Iom 27 I		Margaret	S. Wynn	/wife	. ,	219 D	awso	on Dr.	., Cock	eysv	ille, l	MD 21	030			
ore.	of He of He of He of He of He		20a. Method of Disp		Charles Charles	20b. PI	ace of Dispo	sition (Na matory or	ame of other place)		Date	200	c. Location -	City or To	wn, State		
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Baltimore,	permit. Pag Depertment Important: I any injury o		21. Signature of Fu	ineral Service Licens	90		22	2. Name a	and Address	of Facility							
ä	Depending of the policy of the policy of the policy in the policy of the		Micha	el J. Fla	ale		10	_emm	on Fu	neral H nia Rd.	lome Tin	of Du	ılaney m MT	Val.	ley, li	nc.	
			23a, Part1, Enter t	he disease, or comp	lications that caused	the death	. Do not ent	er the mo	de of dying,	such as cardia	c or respira	tory arrest,	1 11 y - 181 L		Approximat Interval Bet	9	
1	To the Hospital or Attending Physician: The law requires that the death certificate be executed TT To the Pulmiz 24 hours after death. The sentificate has been signed by the attending physicien and TO the Funeral Director. After this certificate has been signed by the attending physicien and TO the Funeral Director, page 2 should be detached for use as the burial transit TT TO TO TO TO TO TO TO TO TO TO TO TO		Immediate Cause	(Final	P_	LA	C			vetasta	Xi.				Onset and I	Death	
			disease or condition resulting in death)	n 🕝	a. Due to (or as	consequ			-	7			-	-	1041	//.	
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89		edi	Y De de la companya d														
Вох		N/N	IF FEMALE: 23b. Was deceden	et pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy								23d. Date of delivery				
m	death s atte d for	icia	in the past 12	months?	4□Pregnant at			⊒t∈ctopic p] Other (s					Month Day Year			rear .	
P.O.	that the death cer ed by the attendir detached for use	Physician/Me	9☐ Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.														
<u> </u>	been signed t should be det	by P										. Did tobac	co use contribute to the cause of death?				
ds		d b		Rend F	ailur							1	2 3 Probably 4 Unknow			Jnknown	
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Records,	he law e has l	Completed	autopsy performed 1 yes 2 1									p	prior to completion of cause of				
Vital	ifcian: Th certificate rector, pag	Be	25. Was case refer	rred to medical	to medical 26. Place of Death												
Ē	Physicia r this cert ral direct		examiner?	7	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient ;			* 3 D	Others			4	S COther (Secretal				
o		To :t	27. Manper of Deat		1 Inpatient 2		28b. Time o		SU DOA 4U Nuising				e 6 ☐Other (Specify) injury occurred		"		
O	ding I h. After funer	tlor	1 Accident	5 Pending investigation	(Month, Da)	Year)	(ear) Injury		28c. Injury at Work? M 1 Yes 2 1								
Division	To the Hospital or Attending Physician: The within 24 hours atter death. To the Funeral Director: Atter this certificate his completely filled in by the funeral director, page	fica	3 🗍 Suicide	6 Could not be							28f. Location (Street and Number or R				l Route Num	ber,	
Ö		Certification:	4 🗍 Homicide	determine	building, etc. (Specify)				City			City or Town, State)					
	spita lours neral		29a. Certifier	Certifying Phy	sician: To the best	of my knov	vledge, deati	h occurred	d at the time,	, date and place	e, and due	to the caus	e(s) and mai	nner as si	ated.		
	e Ho	edical	(Check only one)	2 Medical Exam	iner: On the basis of and manner sta	examinati	ion and/or in	vestigatio	n, in my opin	ion, death occu	urred at the	time, date	and place, a	nd due to	the cause(s)	
	ompi	Me	29b. Signature and title of certifier.										Date signed (Month, Day, Year)				
P	[* GIU						P27730 9/12/01								
0	V/	2	30 Name and adds	rass of parson who o	ompleted cause of d	eath (Item	23a) (Tyne	Print)					- /				
K) \		GARY	COLICT	40. Cr	(9	N. C	MARI	LES SI	x. B1	ATTI	41RA	- 1	1	2120	4	
9	Sta	te	31. Date filed (Mon	nth, Day, Year)	32. Registra	r's Signat	иге			~ ~ ~							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 29788 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JOHNATHAN WILLOUGHBY SEPTEMBER 5, 2005 9:55 P. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE O GENESIS HOMEWOOD CENTER 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 10X M 2 □ F Yrs. 6/29/1954 MARYLAND Director 214-62-7611 Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 TYPes 2 □ No Director MD N/A BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 628 N. EUTAW PLACE 238 APT. 208 21201 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or items 11. Marital Status withIn 72 hours after 1 Yes 2X No If Yes, Give Year or Dates: 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: þ BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) SECURITY CHURCH 12TH GRADE other permit. Pages 1 and 2 should be file.
Depertment of Health and Mental Hy important: If Item 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOSHUA JEROME ELEY CLARA REBECCA WILLOUGHBY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 656 HARRPARK COURT EDGEWOOD, JOSHUA HARRIS/NEPHEW MD. 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State METRO CREMATORY, INC. 9/8/2005 CATONSVILLE, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 and. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician END STAGE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of) Examiner cause (Disease or injury that initiated events resulting in death) Last physician end the burial-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medical 35 ed by the attending detached for use as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ PNEUMONIA 1 Yes 2 No 3 Probably 4 Junknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificete has autopsy performed? 1 ☐ Yes 2 ₽ No 1 Yes 2 3NO 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Tes 2 No 2 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medicai (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 0061789. SEPTEMBER 12 2005 MO

State Registrar 31. Date filed (Month, Day, Year) SEP1 3 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Amend Trend of Brint in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 29789 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** SEPT 10, 2005 ion of Death | 4c. County of Death 2:45pmLouise H. Whitney /Medical 4a Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Examiner 715 Maiden Choice Ln. Apt. CR206 Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□ M 25 F 577-48-0808 92 Yrs. 1913 Colorado FEB. Director Usual Residence of Decedent permit. Pages 1 and 2 should be flied within 72 hours after death with the Meryland Department of Health and Mentel Hygiene. Important: If item 27 is merked other than "nature!, or items 23s or 28s-1 show eny injury or other treumstic event, the Medical Examiner must be presented. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Maryland Funeral Director Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 715 Maiden Choice Ln. Apt. CR206 21228 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: White Baitimore, Maryland 21215-0020 Specify: Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Administrator Day Care Center 18. Mother's Name (First, Middle, Maiden Sumame) **Dora Schneider** 17. Father's Name (First, Middle, Last) Henry Hillman Elizabeth Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen H. Whitney/son 16 Crescent Place Takoma Park, MD 20912 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory, Inc. 9/12/05 Baltimore, MD 21. Signature of Funeral Service Licensee

Dawn F. McDonald 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Pancreatitis Weeks Examiner Due to (or es a consequence of): Be Completed by Physician/Medical Examiner or Attending Physicien: The law requires that the deeth certificate be executed after deeth. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence at .. Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): After this certificate hes been signed by the strungerel director, page 2 should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown artany disease COLOLOCU 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28c. Injury et Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 5 Pending investigation 1 Natural 2 Accident after deeth.
I Director: Aft
ad in by the fur 1 Yes 2 No 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) completely filled in by 4 ☐ Homicide To the Hospital o within 24 hours at To the Funeral D 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) September 12 2005 D30989 7

Registrar

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2005

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Majden Choice Ln Catonsville MD

State of Maryland / Department of Health and Mental Hygiene 2005 29790 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 12:40 PM Yadla September 9, 2005 Nalini /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 10915 Martingale Court Potomac Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Months | Days | Hours | Min. | Dec. 31, 1974 | Northern | Ireland 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 🛱 F 30 Yrs. 577-94-5324 Director Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 27 is marked other than "naturel", or iteme 23a or 28a-f show treumstic event, the Medical Examinat must be notified at 10a. State 1 ☐ Yes 2 🛣 No Directo Maryland Montgomery Potomac 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10915 Martingale Court 20854 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married ☐Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Asian-Indian Completed by If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Physician Medicine 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hema P. Yadla Ratna K. Adusumilli 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Hema P. Yadla/Father 10915 Martingale Court, Potomac, Maryland 20854 other 20b. Place of Disposition (Name of cometery, crematory or other place)
Montgomery
Crematorium, Inc. 20c. Location - City or Town, State 20a Method of Disposition permit. Peges 1
Department of H
Important: if ite
eny injury or ot Sept. 10, 2005 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal Irom State Bethesda, Maryland 4 Donation 5 Other (Specify) Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501 21. Signature of Funeral Service Licensee M00198 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Breast Cancer years /Medical Due to (or as a consequence of) Examiner Brain Metastasis 3 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ol) Examiner physicien and the burial-trensit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: esn. 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown s peen si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy hes pege 2 certificete 1 ☐ Yes 2 No director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 2 1 ☐ Yes 2 No 3 DOA 2 ☐ ER/Outpatient this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No investigation I Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28I. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide within 24 hours at To the Funarel D completely filled in Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number my D38509 September 9 Zook Kerelu Hicholas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nicholas W. Koutrelakos, M.D. 11065 Little Patuxent Pkwy., Columbia, MD 21044 31. Date liled (Month, Day, Year) 32. Segistrar's Signature State 3 2005 Registrar

		1- State of Maryland / Department of Health and Certificate of Death	d Mental H	ygiene 2005	2979
Physici		1. Decedent's Name (First, Middle, Last) ROBERT ACREE	2. Date of D Month	Day Year BER 8, 200	3. Time of Death
/Medie Examin		5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 H	eath MORE Ars. 8. Date of B	4c. County of Death	ice (State or Foreign
Director		Usual Residence of Decedent	11-22-	1951 Maryl	
the Marylan 28a-f show notified at	tor	10a. State 10b. County 10c. City, Town or Location MD NA Baltimore		100	d. Inside City Limits 1X Yes 2 □ No
with the M a or 28a-f be notifie	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Country	y?
11215-0036 within 72 hours after death with the Maryland one. than "natural", or flems 23a or 28a-f show the Madical Examinal must be notified at	by Funerai	1917 Penrose Avenue 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? 14. Was Decedent of Hispanic Origin? 15. Yes 2 □ No If Yes, specify Cuban, Mexican, Purity Year or Dates:	(Specify Yes or Nerto Rican, etc.)	USA 14. Race - Americar Black, White, et Specify: Black	c.
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygiene; 71 is marked other than "natural; or treumatic event, the Modical Exercations and the content of the co	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 15. Decedent's Usual Occupation (Give kind of work done during most of wo	working	16b. Kind of Business/Indu	stry
Maryland 2121 of 2 should be filed within th and Mantal Hygiene. 27 is marked other than treumatic event, the Mary	To Be (17. Father's Name (First, Middle, Last) Robert Acree Sr.	Elsie J	e, Maiden Sumame) Iohnson	
		D17 A / D	imore, MD		ode)
		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date -15-05	20c. Location - City or Town	
Baltimo permit. Pages Department of Importent: It i any Injury or o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P		Owings Mills, MD	
Medical Examiner be executed Examiner bhysicien and bhysicien and sthe burial-transit	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last LIVER CIRRHOSIS Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	BLI		Inset and Death
O. Box 6 the death certify the attending ched for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of delivery Month Da	ay Year
S 8 8 8	ted by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		tobacco use contribute to the c	cause of death?
The law ate has be page 2 st	e Completed	25. Was case referred to medical	1 ☐ Yes	psy prior to complete death? 2 No 1 Yes 2	r findings available etion of cause of
on of ding Phy After this funeral d	ToB	examiner? 1	28d. Describe	dence 6 Other (Specify) how injury occurred	
Divi		4 Homicide determined building, etc. (Specify)	City or To		
Division To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1	ce, and due to the curred at the time,	date and place, and due to the	e cause(s)
7 7 7			55	29d. Date signed (Month, Day Systember 8	2075
27		30. Name and address of person who completed cause of death (Item (23)) (Type, Print) 80 SECE 31. Date filed (Month Park Year)	ours	HOSPITAL	,
Stat Registra	ar	31. Date filed (Month, Day, Year) SEP 1 4 2005 Market B			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $\,2005\,$ 29792 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPTEMBER 11, 2005 **Physician** ETHEL ALPERT 10:40 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 3211 CLARKS LANE #104 BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year) JAN.1, 1908 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. **Funeral** Days Mir Hours 1 □ M 2 🔯 F 218-46-8364 97 Vrs MD Director Usual Residence of Decedent with the Maryland 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: It Item 27 is marked other than "natural", or Items 23a or 28a-i ehow any injury or other traumatic event. The Mudical Experiment must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director MD N/A **BALTIMORE** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3211 CLARKS LANE #104 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE Specify. à 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CAPLAN SARAH ZABLONSKY MAX 19a Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 POMONA WEST, #4 - BALTIMORE, MD 21208 SEVELYN WASSEL / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) SFARD 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) OHR KNESSETH ISRAEL ANSHE 9/13/05 ROSEDALE, MD 21. Signature Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) M-locardla Physician Tunnale /Medical Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial transit that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 pronths? Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 25/10 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 No 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Hesidence 6 ☐ Other (Specify) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of De th 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) SEP 1 4 2005 Registrar

30. Name and address of person v

			State of Man	/land / [Department of Certificate of	Health and	Mental Hygi	•	
Physici /Medio Examir	al	Decedent's Name (First, Middle, Last) Charles Aa. Facility Name (If not institution, give st	A 1 1	M.	Barn 4b. City, Town	es	2. Date of Death Month Septemb	Day Y	
Funeral Director		5. Social Security Number 214-38-7271 Usual Residence of Decedent	7. Áge (/. M. 2□ F	n yrs. last bir	thday) If Under 1 Ye Months Day			Year) 9 -42	Birthplace (State or Foreign Country) Md.
death with the Maryland ms 23a or 28a-f show rmust be notified at	Director	10a. State 10b. County Md. NA 10e. Street and Number	10	Oc. City, Tow	or Location Baltimore 10f. Zip Code	Э	10	ng. Citizen of Wh	10d. Inside City Limits 1 √√ Yes 2 □ No at Country?
草云	Funeral	1 Never Married 2 Married	2. Was Decedent Eve Armed Forces? 1 7 Yes 2 2 No If Yes, Give	#305 or in U.S.		1201 of Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No- to Rican, etc.)		American Indian, White, etc. Black
within 72 hours af iene. than "natural", or the Medical Evan	Completed by	3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	Year or Dates: ation	16a.	Decedent's Usual Oct (Give kind of work do life. DO NOT use ret	ne during most of wo ired)	orking	16b. Kind of Busin	ness/Industry
nould be filed Mental Hygi narked other natic event,	To Be Co	llth grade 17. Father's Name (First, Middle, Last) George	F	Barnes	5	18. Mother's Na	me (First, Middle, N illie	I	Acker
permit. Pages 1 and 2 shou Department of Health and M Important: if Item 27 is men any Injury or other traumat any Injury or other traumat ance.		19a. Informant's Name/Relationship (Type Donald Parks 20a. Method of Disposition 1	Brother	20b. Place or cemete.	. Mailing Address (Stra 7525 Mars Disposition (Name of ry, crematory or other) enmount 22. Name and Ad	ton Road	Date 2 -19-05 Balt	more, Moc. Location - Ci Baltin imore,	Md. 21207 ty or Town, State
Physician /Medical Examiner be portionally franchist fr	Ical Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	My Car	diad onsequence MA ansequence	Interconstructions on the second of the seco	tying, such as cardial force Dislas Failur	ac or respiratory arre	est,	Approximate Interval Between Onset and Death
that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ac. If yes, outcome of 1 □ Live birth 2 { 4 □ Pregnant at tirn 9 □ Unknown	Fetal death	3 □Ectopic pregna 5 □ Other (specify			23d. Date of Month	,
w requires that the been signed by th should be detache	by	Part II. Other significant conditions conf	tributing to death but r	not resulting i	n the underlying cause	given in Part I.	23e. Did tob		ute to the cause of death? Probably 4 \(\sum \) Unknown
The taw ate has b page 2 s	e Completed	25. Was case referred to medical				00 Flore of Do		prid ned2 dea No 1	re autopsy findings available or to completion of cause of tth? Yes 2 \(\text{No} \)
ding Phys n. After this funeral di	To B	exampriner? 1 Yee? 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 28a. Date of Injury (Month, Day Y	28b.	Time of 28c. Injury	Othor	eath (Check only one Home 5 Reside 28d. Describe ho	nce 6 Other	(Specify)
ء ۾ ٿِ ۾	l Certification:	3 Suicide 6 Could not be determined	building, etc. ((Specify)	arm, street, factory, offi		City or Town	, State)	or Rural Route Number,
To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin 29b. Signature and title of certifier	ician: To the best of rier: On the basis of example and manner state	camination ar	e, death occurred at thi d/or investigation, in m 29c. Lic	ny opinion, death occ	urred at the time, da	ite and place, and	d due to the cause(s) Month, Day, Year)
Sta Regist		30. Name and ordress of person who co Mark Komico 31. Date filed (Month, Day, Year) SEP 1 4 200	plet d cause of deal	th (Item 23a) S Signature	29c. Lic (Type, Print)	Grener	rul H	ospita	2

			1 - For State Registrer	State of Ma	aryland / Dep <i>Ce</i>	artment of Fertificate of			iene 19. No. 200	5 2070
	Physici	an	1. Decedent's Name (First, Middle, La. Ethel	st)	Bank			2. Date of Death Month 9 2	Day Year	3. Time of Death 4:10p M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death		4c. County of Deat	
	Funeral Director		5. Social Security Number 213-62-9706 1 Usual Residence of Decedent	□M 2NE	e (In yrs. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 9 - 7 - 5	Year) Co	hplace (State or Foreign untry) Md.
	Maryland -I show	tor	10a. State 10b. County Md. NA		10c. City, Town or L	ocation ltimore	-			10d. Inside City Limits X☐ Yes 2 ☐ No
	h with the 23a or 28a at be roti	al Director	10e. Street and Number 2804 Reisterst	own Rd.		10f. Zip Code	21215	10	og. Citizen of What Co USA	ountry?
5-0036	within 72 hours after death with the Maryland ene. Than "natural", or Itams 23a or 28a-f show the Marical Exertines must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Armed Forces? 1 Tyes 2 The Street		Was Decedent of Hif Yes, specify Cub.	dispanic Origin? (Sl an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify:	
21215-0	within 72 ho iene. • than "natur ir e Medic	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12th grade	ducation ide completed) College (1-4or !	(Giv. 5+)	edent's Usual Occup e kind of work done DO NOT use retire	during most of wor	king	16b. Kind of Business/	Industry
	2 should be filed within and Mental Hygiene. Is marked othar than aumatic avant, It a M.	To Be C	17. Father's Name (First, Middle, Last, Robert		Banks	2022204	18. Mother's Nam Ethe	ne (First, Middle, M		on
3altimore, Maryland	of Health of Health if itam 27 or other tr	-	19a. Informant's Name/Relationship (Willie Mae Jol 20a. Method of Disposition 1 Burial 2 Cremation 3 C 4 Donation 5 Other (Specific	nnson Co	ousin 2	2804 Rei	sterstw	on Rd.,	City or Town, State, 2 Baltimor Oc. Location - City or Lansdowne	Town, State
Baltir	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licer			2. Name and Addre	ss of Facility .H. Eas		ltimore, l E. Nort	Md. 2120 ch Ave.
8760,	Physician and /Medical pe executed /Medical physician and tor use as the burial-transit	dical Examiner	23a. Part1. Enter the disease, or composed to shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a. Due to (or as c.	a consequence of):	A E	A105	A PARTIES DIE		Approximate Interval Between Onset and Death My GAR.
.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant al	2 Fetal death 3	□Ectopic pregnancy	,		23d. Date of deli Month	ivery Day Year
0	w requires that the de been signed by the should be detached	by	Part II. Dther significant conditions of	ontributing to death b	out not resulting in the	underlying cause giv	en in Part I.		acco use contribute to	_
al Records,	: The law requicate has been page 2 should	Completed						24a. Was an autopsy perform 1 — Yes 2	ed? prior to death?	topsy findings available completion of cause of
Division of Vital	To the Hospital or Attending Physician: The I within 24 butus after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	e 28e. Place of Inj		of 28c. Injur Wor M 1	ier: 42 Nursing H	28d. Describe how	nce 6 Other (Spec	
D	To tha Hospital or A within 24 hours after To tha Funaral Dirac completely filled in by		29a. Certifier Certifying Ph (Check only 2 Medical Exar	ysician: To the best	of my knowledge, dea			, and due to the car	use(s) and manner as	
)	To tha within 2 To tha complet	Medical	29b. Signature and title of certifier	and manner sta	ated.	29c. Licens			d. Date signed (Month	
!	30		30. Name and address of person who	completed cause of c	death (Item 23a) (Type	Print)	ERTY 6	20AD R	EPTEMBER ANDALSTO	un mD.
	Sta Registr		31. Date filed (Month, Day, Year) 200	5 32. Registr	Q (O					

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Phys /Me	ician dical	ofeverand 2. Dyradding	SEFTE	
Exan	niner	Saint Joseph Medical Center	4b. City, Town, or Location of Death TOWSON	4c. County of Death Baltimore
Funer Directo		5. Social Security Number 215-14-0650 6. Sex 192 M 2 F 83 Yr	Months Days Hours Min. (M	ste of Birth 9. Birthplace (State or Foreign Country) 9. 5,1922 N. Carolina
Maryland f show	٥	10a. State 10b. County 10c. City, Town	imore	10d. Inside City Limits ▼□ Yes 2 □ No
with the fa or 28a-	Direct	10e. Street and Number 950 Argonne Drive	10f. Zip Code 21218	10g. Citizen of What Country?
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21215-0036 Id within 72 hours at glene. or than "naturel", or the Wedical Exem	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ecedent's Usual Occupation Sive kind of work done during most of working fe. DO NOT use retired) Storekeeper	16b. Kind of Business/Industry Domino Sugar
	To Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First Mae Roo	t, Middle, Maiden Sumame) k
Mary and 2 should be a should		19a, Informant's Name/Relationship (Type, Print) 19b. N	Mailing Address (Street and Number or Rural Rout O argonne Drive Bal	te Number, City or Town, State, Zip Code) timore, Maryland 21218
Baltimore, Marylar permit. Pages 1 and 2 should by Department of Health and Menta Important: if New 27 is marked any injury or other traumatic ev		1- Buriet 3 Commettee 3 Demoval from State cometery,	isposition (Name of crematory or other place) 9/20/0 son Forest Vet. Cem	5. Owings Mills, Md
Balti permit. Departn Imports	once.	21. Signature of uneral Service Lensee		an-Harris Funeral Home Rd Baltimore,Md 21215
Pnysicia	in i	23a. Part. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition CHRONIC LYMFH)	t enter the mode of dying, such as cardiac or resp DCYTIC LEUKEMIA	Approximate Interval Between Onset and Death
9760, ate be executed	er Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of CARC I NOMA OF Due to (or as a consequence of Due to (or as a	: THE PROSTATE :	YEARS
, P.O. BOX 61 that the death certific ed by the attending p detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery Month Day Year
ds, P. Lires that the signed by do be deta	٤	Part II. Other significant conditions contributing to deal in but not resulting in t	ne underlying cause given in Part I. 2	3e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
II Records, The law requires t cate has been signe page 2 should be				4a. Was an autopsy findings available prior to completion of cause of death? ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No
of Vital Re Physician: The rithis certificate ha	To Be	examiner?	26. Place of Death (Che attent 3 DOA Cther: 4 Nursing Home 5	ick only one) 5 Residence 6 Other (Specify)
ding After fune	atlon. T		ne of 28c. Injury at 28d. D	Describe how injury occurred
Division the Hospital or Attening 24 hours after death the Funeral Director: appletely filled in by the	Cortification:	3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm building, etc. (Specify)	1, street, factory, office 28f. Lc	ocation (Street and Number or Rural Route Number, jty or Town, State)
To the Hospital or within 24 hours afte To the Funeral Dir	Madical		death occurred at the time, date and place, and du or investigation, in my opinion, death occurred at t	ue to the cause(s) and manner as stated. the time, date and place, and due to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier	29c. License number D 25886	29d. Date signed (Month, Day, Year) Seh. 12 - 2006
3		30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print)	7172 2003
45 0 K. 055 1	State istra	31. Date filed (Month, Day, Year) 32. Rigistrar's Signature	LER DRIVE TOWSON, M	ARYLAND 21204

			1 - For State Registrar	State o	f Maryla		artment of H rtificate of L		ental Hygier	2011	5 2979	
	Physical		1. Decedent's Name (First, Middle, La	ist)	-						3. Time of Death	
	Physici /Medio		James		ee		Baer		September	Day 2005	2:40 p M	
	Examin	er	4a. Facility Name (If not institution, given 113 Water Street		nber)			Location of Death		4c. County of Dea		
	·				7 Ann //n um	s. last birthday)	Freder		O Date of Birth	Frederick		
	Funeral Director			1. M 2□ F	7. Age (III yi		Months Days	Hours Min.	8. Date of Birth (Month, Day, Yes	orth Pay, Year) 9. Birthplace (State or Foreign Country) Maryland		
	σ		Usual Residence of Decedent					T.	arch 20,	1937 Mai	yrand	
	anylar show	-	10a. State 10b. County		10c. C	City, Town or Lo	ocation				10d. Inside City Limits 1 X Yes 2 □ No	
	the M	Director	Maryland Frederic 10e. Street and Number	K	Fre	ederick	10/ 7:- 0-1-	<u></u>		0		
	with 3a or		113 Water Street				10f. Zip Code 21701			Citizen of What Co	ountry?	
	death ms 2	Funeral	11. Marital Status	12. Was Dece	dent Ever in	U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spec	US.	14. Race - Ame		
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. od other then "naturel", or flems 23a or 28e-f show event, tre Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed For 1 ☐ Yes If Yes, Giv Year or Da	2 ፟፟፟፟፝ No e		If Yes, specify Cubar 1 ☐ Yes 2 🌠 No	n, Mexican, Puerto R Specify:	lican, etc.)	Black, Whit		
2-0	72 ho	Completed	15. Decedent's E (Specify only highest gr.				dent's Usual Occupa		16b.	. Kind of Business		
21	c * //	npie	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT use retired)	uring most of working	g			
12	filed w Hygier Afher th		9 17. Father's Name (First, Middle, Last			Superv	-	40.44.4.4.4.4		eaning Se	ervice	
anc	should be filed withir nd Mental Hygiene. marked other then umatic event, ILE M.	Be c						18. Mother's Name		,		
ary	s 1 and 2 should f Health and Men Item 27 is marke other treumatic	ဥ	Franklin Thomas Ba 19a. Informant's Name/Relationship (19b. Mailir	ng Address (Street a	Mary Eliza			Zin Code)	
	tre tre		Deb LaGrove, niece	≘			Vater Stre				21701	
ore,	of Hei		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐		20b.	Place of Dispo	sition (Name of matory or other place	Da	te 20c.	Location - City or		
Ĕ	Pag ment ent: b		*4 □Donation 5 □ Other (Special				n Memoria	19/9/20	Fre	ederick,	Maryland	
Baltimore,	permit. Pages 1 and Department of Healt Importent: If Item 2 any injury or other once.		21. St natural of Funeral Service Lice	Dron -	MOO	1999 10	2. Name and Address 06 East Ch	^{s of Facility} Keen nurch Stre	ey and Ba	asford Fu	neral Home yland 21701	
	-		23a. Part1. Enter the disease, or com shock or heart failure. List only	plications that ca	used the dea	ath. Do not ent	er the mode of dying	, such as cardiac or	respiratory arrest,	22010, 1101	Approximate Interval Between	
2	Pnysician	8 1	Immediate Cause (Final disease or condition			r with	Metastasi	ls			Onset and Death	
	/Medical Examiner		resulting in death)		or as a conse							
		-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	equence of):						
V	uted ansit	Examine	Cause (Diseese or injury	220 10 (
oʻ	exect an and rial-tra	Еха	that initiated events resulting in death) Last	Due to (or as a conse	quence of):						
58760,	cate be executed physician and the burial-transit	edicai	(d								
	- 03	-	IF FEMALE:									
Вох	law requires that the death certift as been signed by the attending 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?		ome of pregr nth 2 ☐ Fet ant at time of	tal déath 3□	Ectopic pregnancy			23d. Date of deli Month	very Day Year	
o.	res that the de signed by the a be detached f	ysic	1 Yes 2 No 9 Unknown	9□ Unkno		death 5_	Other (specify)				,	
s, P	s that ned b	by Pr	Part II. Other significent conditions	contributing to de	ath but not re	sulting in the ur	nderlying cause giver	n in Part I.	23e. Did tobacco	use contribute to	the cause of death?	
rds	w require: been sig should by	ed b							1 ☐ Yes	2 🕅 No 3 🗆 Pro	obably 4 Unknown	
Vital Record	aw requas been 2 should	Completed							24a. Was an	24b. Were au	topsy findings available	
Ě	The ate h page	Com							autopsy performed? 1 ☐ Yes 2 🛣 N	death?	completion of cause of	
/ita	Attending Physicien: The rideath. ector: After this certificate hiby the funeral director, page	Be (25. Was case referred to medical examiner?					26. Place of Death (
of	Physi this c al dire	5	1 ☐ Yes 2 💢 No			ER/Outpatien		4 Nursing Home	5 🕅 Residence	<u></u>	eify)	
uo.	I or Attending Ph after death. Director: After th i in by the funeral	ertification;	27. Manner of Death 1 X Natural 5 ☐ Pending		n, Day Year)	28b. Time of Injury	Work?		d. Describe how inj	ury occurred		
Division	Attender deatl ctor:	fical	2 Accident investigation 3 Suicide 6 Could not b		of Injury - At I	nome, farm, stre	eet, factory, office	es 2 □ No	f. Location (Street a	and Number or Ru	ral Route Number	
á	in Sir or	Serti	4 Homicide	buildin	g, etc. (Spec	ify)			City or Town, Sta	te)	a note number,	
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	calC	29a. Certifier 1 Certifying Ph	ysician: To the	best of my kn	owledge, death	occurred at the time	, date and place, an	d due to the cause(s) and manner as	stated.	
	the H hin 24 the F nplete	Medical		and mann	er stated.	ation and/or inv	restigation, in my opin					
	To To		29b. Signature and title of certifier.	man	20		29c. License	number		ate signed (Month		
,			30. Name and address of same	completed	of death //c	m 22c) (T :	D01711		Sept	ember 7,	2005	
	4.		30. Name and address of person who Timothy F. Hickey					Frederick	, MD 217	02-4359		
	Sta	te	31. Date filed (Month, Day, Year) SEP 1 4 200						,	557		
	Registra	ar	DEP 1 4 200) Slat	מ כמ	ature						

			1 - For State	State of Maryla	ind / Depa	artment of H	lealth and N	Mental Hygie	ene 200	5 2979
			Registrar 1. Decedent's Name (First, Middle, Last)		inicate of t	Dealii	2. Date of Death	J. No.	3. Time of Death
	Physici /Medi		Bernardine M. Bru	10				Septom be	Day Yea	5 12:05 B
	Exami		4a Facility Name (If not institution, give			4b Gity Town, or	Location of Death	THE PARTY OF THE P	4c. County of De	rath
		И	Del Air Healt	h Teha	b Ctr.	Del	Hiv		Har	ord
н	Funeral Director		5. Social Security Number 6. Se 123-01-1205	IM OME	"	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		irthplace (State or Foreign Country)
			Usual Residence of Decedent	9	2			06/28/19	13 Ma	aryland
	nylan show	_	10a. State 10b. County	10c. (City, Town or Lo	cation				10d. Inside City Limits
	Ba-f s	Director	MD Harford		Abingdon					1 ☐ Yes 2 X No
	with th	Dire	10e. Street and Number		- 1	10f. Zip Code		10g	g. Citizen of What (Country?
	eath v	erai	3829-A Memory La	ane 12. Was Decedent Ever in	11.0	21009			U.S.A.	
	iter d	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 Yes 2 No	U.S. 13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	
93	al', ol	b	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2X No	Specify:		Specify:	hite
5-0036	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show disal Examinat must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Deced	ent's Usual Occupa	ation during most of work	ing 16	ib. Kind of Busines	
2121	within iene. than "	mpje	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	O NOT use retired)	nig		
7	filed v Hygie othar t		17. Father's Name (First, Middle, Last)		Cut	ter	10 Matheda Nasa		Lebow Br	others
ano	d be f	o Be						e (First, Middle, Ma	iden Sumame)	
Maryland	2 should be f and Mental H Is marked of aumatic ava	10	Theodore Hoffman 19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin	Address (Street a	Elizabe	th Butz al Route Number, C	ity or Town State	Zin Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Itam 27 Ia marked other than "naturat", or Itams 23a or 28a-f show other traumatic avant. It Mixelical Examinar must be notified at		Rita A. Hartraní	t (Gr.Daught						
Baltimore,	es 1 a of Hea fitam rothe		20a. Method of Disposition	20b.	Place of Dispos	ition (Name of atory or other place			c. Location - City of	
Ē	Pag nent ant: I		1 XBurial 2 ☐ Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)		·=		· 1	2/2005 T:	imonium	Maryland
Salt	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service Licens	99	22.	Name and Addres	s of Facility E	F. Lassah	n Funera	1 Home, P.A.
			C. SI Va		11	750 Belai	ir Road -	Kingsvil	le, Mary	land 21087
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	ne cause on each line.	ath. Do not ente	O 4 -		or respiratory arrest	,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Onen.	31	-OHN ((R)	-		3 Man Mt
	Examiner			Due to (or as a conse	equence of):					
		Je.	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a conse	equence of):					
V	be executed sician and burial-transit	Examiner	that initiated events							
, 0	e exe ian ar urial-t	I Ex	resulting in death) Last	Due to (or as a conse	equence of):					
8760,	cate be executed physician and the burial-transit	dical		l						
9		/Me	IF FEMALE:	3c. If yes, outcome of pregi	nancy			_		
Вох	death certifi e attending p id for use as	Physician/Me	in the past 12 months?	1 Live birth 2 Fe 4 Pregnant at time of	tal death 3 □	Ectopic pregnancy Other (specify)			23d. Date of de Month	Blivery Day Year
o.	the d y the ichec	nysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown	300	Ottler (specify)				
s, P	requires that een signed b nould be deta	by Pi	Part II. Other significant conditions con	tributing to death but not re	sulting in the un	derlying cause give	n in Part I.	23e. Did tobac	co use contribute (o the cause of death?
rds	w require been sig should b							1 ☐ Yes	2 ₽ No 3 □ P	robably 4 Dunknown
Record	aw is b	ompieted						24a. Was an	24b. Were a	utopsy findings available
_	The ate h page	Com						autopsy performed 1 ☐ Yes 2 ☐	1? death?	completion of cause of
Vital	sician: certific rector,	Be	25. Was case referred to medical examiner?				26. Place of Death			
of \	hys this al di	7	1 ☐ Yes 2 ☐ No		ER/Outpatient	3□ DOA Other	4 Tursing Hor	me 5 Residence		ecify)
		tion	1 Aatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work' M 1 □ Y	at ? 'es 2 ∐ No	28d. Describe how i	njury occurred	
Division	ttan deat ctor: / the	ertification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At I	nome, farm, stre		-	28f. Location (Street	t and Number or F	ural Route Number
-	r i i e	erti	4 Homicide	building, etc. (Spec	ify)	i, radiory, omeo		City or Town, S	tate)	arai riodio Nambor,
	Hospital of the sale of the sa	calC	29a. Certifier 1 Certifying Phys	ician: To the best of my kn	owledge, death	occurred at the time	e, date and place, a	and due to the cause	e(s) and manner a	s stated.
)	To the Hos within 24 h To the Fur completely	ledical	one)	and manner stated.	ation and/or inve	estigation, in my opi	inion, death occurre	ed at the time, date	and place, and due	e to the cause(s)
	To tha I within 2 To tha I complet	Σ	296. Signature and title of certifier	Robe	sul m	29c. License	number	29d.	Date signed (Mont	h, Day, Year)
	,		yankus		unch	102	0126	, 9	775	
	C		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type, P	BOA.	11. 411	2101	4	
	Sta	te	31. Date filed (Month, Day, Year)	3 Registrar's Sign	ature		W WOLL	, -101	<u> </u>	
	Registr	-	SEP 1 4 2005	Elever IF	Books!)				

				State of Marylan State of Marylan State of Marylan For State of Marylan For State of Marylan State of Marylan For State of Marylan State of Marylan State of Marylan State of Marylan	d / Depa	artment	of H	ealth and M		21	005 29798
		Physici		1. Decedent's Name (First, Middle, Last) Clayton F. Bollack, Sr.	/ 9/16	/US ^a 91	HOI!	Jean	2. Date of De Month	ath Day	3. Time of Death
		/Medic Examir		4a. Facility Name (If not institution, give street and number)		4b. City, 1	Town, or	Location of Death	Septen	ber 10,	
		LXGIIII	ici	Upper Chesapeake Medical Center	f	Be]	l Ai	r		Harf	ord
00:30		Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. 1218-01-7761 85	last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birn (Month, Da July 1	th y, Year) 1920	9. Birthplace (State or Foreign Country) Maryland
D		aryland •how	2	Usual Residence of Decedent 10a. State 10b. County 10c. City Md. Harford	y, Town or Lo	cation	Jo	рра			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
8		or 28a-f	Directo	10e. Street and Number		10f. Zip		005		10g. Citizen of V	Vhat Country?
9116bs		be filed within 72 hours after death with the Maryland tat Hygiene. do other than "natural", or Itams 23e or 28e-f ehow od other than "natural", or Itams 20e roffled at event, the Modical Exertiner must be notified at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	S. 13. \	Was Deced		085 ispanic Origin? (Spin, Mexican, Puerto	ecify Yes or No Rican, etc.)		e - American Indian, ik, White, etc.
	9000	nours afte ural', or It I Exertin	by	1 Never Married 2 Married 1 Myes 2 No If Yes, Give Year or Dates:		1□Yes 2		Specify:		Specify	
	215-0036	ithin 72 ł ne. nen "netu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		kind of wor DO NOT us	k done d e retired	during most of work)			isiness/Industry
1	121	filed w Hygier sthar th		12 years 17. Father's Name (First, Middle, Last)	route	and	sare	s managel			
3/6	Maryland	2 should be filed withir and Mental Hygiene. Is marked othar than aumatic evant, Ire M	To Be	Benhardt Bollack	T 121			Madeline	Henni	gan	~
惠		and 2 sh salth and n 27 is m		19a. Informant's Name/Relationship (Type, Print) Dorothy Bollack/wife	524	B Riv	iera	Drive,	Joppa, 1	Md. 2108	55
MP #M&DOCH	Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any injury or other traumatic evonce.		1 Payriot 2 Cromation 3 Removal from State	Place of Dispo Temetery, cren ghview	natory or ot	her piac	θ)	²⁰⁰⁵	Fallsto	City or Town, State
H	Balti	permit Departn Importa any inju		21. Signature of Funeral Service Licensee				ss of Facility Funeral cPhail Ro			
Š				23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final	n. Do not ente	er the mode	of dyin	g, such s cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
		Physician /Medical Examiner		disease or condition resulting in death)	uence of):	Hea	nt	factur	e.		20065
	8760,0	be executed ician and burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequen		Lliv	-d.0	Vaseu (a	n cise	ese.	Vyears
55.	.O. Box 6	the death certifica by the attending pt ached for use as t	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of displayments.	Ideath 3□	Ectopic pre				23d. Dat Moi	e of delivery nth Day Year
B	ds, P	uires that n signed b	d by P	Paul Other significant conditions contributing to death but not resi	ulting in the ur	nderlying ca	use give	en in Part I.	_	_	ibute to the cause of death? 3 Probably 4 Onknown
Boll	Il Records,	aw as b	Completed	Heral filo lation.					24a. Was autor perfo 1 \(\text{Yes} \)	rmed?	Were autopsy findings available prior to completion of cause of leath? Yes 2 No
~	Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner? Hospital:			Othe	26. Place of Death			
R	of	g Phys er this eral dir	n: To	27. Manner of Death 28a. Date of Injury	ER/Outpatien 28b. Time of		A Bc. Injury Work	er: 4 ☐ Nursing Ho		dence 6 Other	
3	Division	Attending Far death. Sctor: After by the funer	Certification:	1 Matural 5 Pending (Month, Day Year) 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At ho	Injury	М	1 🗆 '	Yes 2 □ No	28f Location (Street and Numb	er or Rural Route Number,
0	Div	ital or A		4 Homicide delormined building, etc. (Specify	y)				City or Tov	vn, State)	
		To the Hospital or Attending Physician: The I within 24 hours after death. To the Funaral Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my kno 2 Medical Examiner: On the basis of examina and manner stated.	wledge, death tion and/or inv	n occurred a vestigation,	in my o	ne, date and place, pinion, death occurr	and due to the ed at the time,	cause(s) and ma date and place, a	nner as stated. and due to the cause(s)
		With To I	×	29b. Signature and title of pertifier	7			o number		29d. Date signed	(Month, Day, Year)
	•	di		O Name and Aress of person who completed cause of death (Item			114	Edon	1111	DZINU	0
		Sta Regist	ate rar	31. Date filed (Month, Day, Year) SEP 1 4 2005		heale)	9	7 700	ac I'll		<u> </u>
			- 2	1-0000							

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	TIAM DI	. O w	For State Registrar	State	of Mar	ryland	•	artment <i>tificate</i>			nd Me	ental Hy	giene Reg. No		^ ~	
	Physici	an	1. Decedent's Name (First, Midd	le, Last)								2. Date of De		4	Vear	3. Time of Goay 9
	/Media	cal	William Brown 4a. Facility Name (If not institution	n aire street and a	umbael			4h Cib. Te		ocation of		Septem				20:29 M
do	Examir	ier	4125 Callaway		imoer,					imore	Death		40	County o	or Death	
	Funeral Director		5. Social Security Number 216–44–1003	6. Sex 1 M 2 ☐ F	7. Age ((In yrs. last	t birthday) Yrs.	If Under 1		If Under 24 Hours	4 Hrs.	B. Date of Bir	th 1946	7	9. Birthp Coun Mary	lace (State or Foreign try) and
	and w		Usual Residence of Decedent 10a. State 10b. County	,		10c. City, T	fown or Lo	cation							14	0d. Inside City Limits
	Maryli febo	ror	Maryland	N/A	}	Balti		oution.							,	1 Ves 2 □ No
	r 28s	Director	10e. Street and Number		1		.,,,,,,,	10f. Zip C	ode				10g. Cit	izen of W	hat Coun	try?
	23a c		4125 Callaway A	venue				2121	5				Uni	ted S	State	es
21215-0036	ges 1 end 2 should be filed within 72 hours after death with the Maryland it of Heelih and Mental Hygiene. If item 27 is marked other then "netural", or items 23a or 28s-1 ehow or other traumatic event, if a Medical Examinat rusal be notified at	by Funeral	11. Marital Status 1 Never Married 2 Mai 3 Widowed 4 Divorces	If Vas G	orces? 2 No ive			Was Deceder f Yes, specify	Cuban	panic Origir , Mexican, I Specify:	n? (Spec Puerto R	rfy Yes or No ican, etc.))-	Black	, White, o	rican
2-0	72 ho	eted		nt's Education)	1		ient's Usual			of working	9	16b. K	ind of Bus	Indi	
121	within ene. then	Completed by	Elementary/Secondary (0-12)	T .	(1-4or 5+)) _N	life.	DO NOT use	retired)			9	Ci L			
	Hygie Hygie other t	ဝင္	12 17. Father's Name (First, Middle,	Last)		I.	MIIIL	aince				(First, Middle,	Cit	<u> </u>	A)	
Maryland	ld be ental ked o	To Be	William Raymond						1	/alett			, 10001	oumanne	,,	
ary	a mari	-	19a. Informant's Name/Relation		·····		19b. Mailir	g Address (S				Route Numb	er, City o	r Town, S	State, Zip	Code)
	end 2 leeith a m 27 li		Mary McKesson -	Ex-Wife		_				renue	Balt	imore	, Ma	rylar	nd 21	215
Baltimore,	Pages 1 nent of Hi int: If iter		20a. Method of Disposition 1 Surial 2 ☐ Cremation	3 □Removal from	State	cem	etery, crer	sition (Name natory or othe	or place)	4	Da			ocation - C	•	
I iii	it. Pa rtmen rtant: njury		4 Donation 5 Other (S	-		Oakl		Cemete			9/17/	2005	Bal	timor	re, M	Maryland
Ba	Depermine timbo		* Kathlee	n Web	ex	155			th C	ber F heste				P.A. imore	e, ME	21231
			23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final	r complications that t only one cause on	caused the	ne death. I	Do not ent									Approximate Interval Between Onset and Death
)	Physician /Medical		disease or condition resulting in death)	a. Ath	1500	consequen	T/C	lard	wa.	scup	rd	1848				
	Examiner				(01 43 4 1	consequen	ice oi).									
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to	(oras a	consequen	ice of):									
	ecuter and trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	C	/											
8760,	cate be executed physician and the burial-transit	al E		Due to	(or as a	consequen	ice ot):									
687		edical		d												****
.O. Box	et the death certific by the ettending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		birth 2 nant at tir	pregnancy Fetal deme of death	ath 3□	Ectopic preg Other (spec						23d. Date Mont		ry Day Year
<u>α</u>	es thet igned b be deta	by Pi	Part II. Other significant conditi	ons contributing to	death but	not resultin	ng in the u	nderlying cau	se given	in Part I.		23e. Did t	obacco u	ise contrib	oute to th	e cause of death?
ıd	v require been sig should b	ted t										10	Yes 2	□No 3	B 🗀 Proba	ably 4 Unknown
Division of Vital Records,	e lay	Completed												pr	ior to con eath?	psy findings available appletion of cause of
/ita		Be	25. Was case referred to medica examiner?						·		f Death (Check only o			7	
d	shys this	L.	XXYes 2 □ No 27. Manner of Death		Inpatient		/Outpatien		Other	4 LI Nursi		e 5∐ Resid				SCENE
O	g f e	tlon	1 Natural 5 ☐ Pendi	28a. Date (Mo) gation	nth, Day	Year) 28	b. Time of Injury	M 280	Injury a Work?	at es 2∐No		d. Describe t	now injur	y occurre	d	
/isi	Attending r death.	fica	3 ☐ Suicide 6 ☐ Could	not be 28e. Plac	e of Injury	/ - At home	, farm, str	et, factory, o		25 2		f. Location (S	Street an	d Numbei	r or Rural	Route Number.
á	s efte	Certification;	4 🗋 Homicide determ	build	ling, etc.	(Specify)						City or Tox	wn, State)		
,	To the Hospital or Attendi within 24 hours effer death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 1 ☐ Certifyi (Check only one) 1 ☐ Certifyi	ng Physician: To th Examiner: On the I and mar	e best of basis of e nner state	xamination	dge, death and/or inv	occurred at restigation, in	the time my opir	, date and p nion, death	place, an occurred	d due to the	cause(s) date and	and man	ner as stand due to	ated. the cause(s)
	To t To t	Σ	29b. Signature and title of certific	or a second	10			29c. L	icense r							Day, Year)
,	2		· Cubric	UCK 7	7	F"			0.	.C.M.I	Ε.		Sept	embei	07,	2005
	5		30. Name and address of person	AH A	-4		111	Print) Penn	Stre	eet, I	Balt:	imore,	Mar	yland	1 212	201
	Sta , Registr		31. Date filed (Month, Day, Year	G.	Registrar:	s Signature	Soa	de								

		1 - State Registrar	State of Maryland / [Department of F Certificate of			ene 200	5 2980
Physic /Medi		Decedent's Name (First, Middle, La JOHN HOC	CK BROOKS		S	2. Date of Death	ළ ^{⊅a} ්ෂ, උ ල්ලී ්	3. Time of Death 6 # 14F M
Exami	ner	4a. Facility Name (If not institution, git Saint Joseph	e street and number) Medical Center	4b. City, Town, o	TOWSOT	3	4c. County of De	ath simore
Funeral Director		155-14-0931	Sex 7. Age (In yrs. last bir	rthday) If Under 1 Year Yrs. Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth - Month, Day - ebruary 8	, 1923 Mar	rthplace (State or Foreign ounity) 'Yland
Maryland a-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimo	ore Tim	m or Location				10d. Inside City Limits 1 □Yes 277No
with the	i Dire	10e. Street and Number 2525 Pot Spring F	Road	10f. Zip Code	1093	10	g. Citizen of What C	ountry?
ie, Ivida y idition 2 12 13 10000 s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23s or 28s-1 show other traumatic event, the Macidial Exprising must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Agried Forces? 1. Ves 2 No WWII If Yes, Give Year or Dates:	13. Was Decedent of H		cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: Wh	ite, etc.
within 72 ho liene. r than "natur tha Madical.	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired Broker	pation during most of workir d)	ng 16	Insuran	
I be filed ntal Hyg od other: event,	Be	17. Father's Name (First, Middle, Last Rodney Joseph Bro			18. Mother's Name Mary Agn		aiden Sumame)	
0.00	10	19a. Informant's Name/Relationship	Type, Print) 19b	D. Mailing Address (Street	and Number or Rura	l Route Number, (City or Town, State,	Zip Code)
os 1 and 2 a		Edith Boggs Brook	20b. Place of	2525 Pot Spi f Disposition (Name of ry, crematory or other place	D		Dc. Location - City o	r Town, State
Page nent of ant: If ury or		1 Burial XX Cremation 3 [Donation 5 Other (Special Section 2), Signature of Funeral Service Lice	GreenM	lount Cemeter	ry 9/12		altimore	•
permit. Depertrimports imports any inji		21/ Signature of Funeral Service Lice MMM H	En Jona Rus	22. Name and Addre	ess of Facility Mitc 6500 York		erela funera Limore, Mary	
Physician		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		not enter the mode of dyin			t,	Approximate Interval Between Onset and Death
/Medical Examiner			Due to (or as a consequence SEPSIS	of):				
icate be executed physicien and sthe burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c					
	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy		/		23d. Date of de	livery Day Year
uries that the death cer signed by the ettendir d be detached for use	hysic	1 Yes 2 No 9 Unknown	4□Pregnant at time of death 9□ Unknown	5 Other (specify)				
w requires that been signed should be de	by	Part II. Other significant conditions	contributing to death but not resulting in	n the underlying cause giv	en in Part I.	23e. Did toba		the cause of death?
2 8 2	Completed					24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
To the Hospital or Attending Physician: The Within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 1 1 27. Magner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Time of 28c. Injury Work	y at 2		ce 6 Other (Spe	icity)
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	e 30a Olasa of Injury At home for			8f. Location (Stree City or Town,	et and Number or R State)	ural Route Number,
• Hospi 124 hou • Funer letely fill	edicai	29a. Certifier TD, Certifying Pl (Check only one) 2 Medical Example 1	nysician: To the best of my knowledge miner: On the basis of examination and and manner stated.	e, death occurred at the tind d/or investigation, in my o	ne, date and place, a pinion, death occurre	nd due to the caus d at the time, date	se(s) and manner as and place, and due	s stated. to the cause(s)
To th within To th	Me	29b. Signature and title of certification	for M.D.	29c. Licens		29d	Date Rigned (Mont	h, Dey, Year)
1,3		30. Name and address of person who TIMOTHY LOW M.	completed cause of death (Item 23a) (D. 7601 OSLER I		ON. MARY	LAND 2:	1204	
Sta Regist		31. Date filed (Month, Day, Year)	32. Registrates Signature 4 2005	H books		andre 6	•	

		1	For State Registrar	State of Ma		epartmen Certificat				Reg. N	21111		
	Physicia	an	1. Decedent's Name (First, Middle, La. Frances M	st) Mary Bierl:	ing				2. Date of Sept.	ember	² ay 8, 2 00	3. Time of Death 10:45 AM M	
	/Medic Examin	er	4a Facility Name (If not institution, give Home -5915 Abrid	e street and number)	Apt.P	4b. City,		Location of I	ge		lc. County of Dead Howard	th	
	Funeral Director		5. Social Security Number 6. S 169-40-9060 1	ex x 7. Age □ M 2□ F	(In yrs. last birthe 56 Yr	Months s.	1 Year Days	If Under 24 Hours		f Birth 1 4 1 9 2	9. Bin PA	thplace (State or Foreign buntry)	
	p.	-	Usual Residence of Decedent		10.00								
	show		10a. State 10b. County MD Howard		10c. City, Town of Elkride							10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	Ba-f	Director			DIRTING					1.0			_
	23a or 2	ai Dir	10e. Street and Number 5915 Abrianna Way	APt. P		10f. Zip 210	25-			US.	Citizen of What Co A	ountry?	
980	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examplest must be multified at	by Fur	11. Marital Status X 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E- Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Deced If Yes, spec 1 \(\superstack \text{Yes}\)		spanic Origir n, Mexican, I Specify:	n? (Specify Yes o Puerto Rican, etc	or No- .)	14. Race - Ame Black, Whit		
20	72 hc natur	sted	15. Decedent's Ed (Specify only highest gra	ducation	16a. D	ecedent's Usua	al Occupa	ition Jurina most o	of working		Kind of Business	Industry	
2	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+		Give kind of wo ife. DO NOT u k Telle)	g	Da	nking		
2	filed w Hygier other th	S	17. Fathada Nama /First Afiddla / act	2				19 Mothod	Nama /First Ati	ddlo Maid	a Sumano)		_
Maryland 21215-0036	2 should be fi and Mental H Is marked ot raumatic ever	To Be	17. Father's Name (First, Middle, Last, Denning						s Name (First, Mi orence Benso		an sumame)		
	1 and 2 sho Health and tem 27 Is mu		19a.Informant's Name/Relationship (William Bierling	Type, Print)							or Town, State, 2 ge, MD 2		
Baltimore,	Pages 1 a ent of He nt: ff item ry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Specif		1	crematory or c	ther place		Date Sep 1 der2005	2	Location - City or	Town, State lle, Marylar	=
Baltiı	permit. Pages 1 Depertment of H Important: If ite any Injury or ot once.		21. Signature of Funeral Service Licer			Halight P.O. Bo		s of Facility ral Ho	me & Chap	pel , Marvl	P.A. Land 2178	4	
			23a. Part1. Enter the disease, or com	plications that caused t	he death. Do no						Laria Elio	Approximate	_
	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	BRI	MIF		AS	TAS	SES			Interval Between Onset and Death Z Months	>
	Examiner			BRE	CAST	CF	210	CER				8 months	S
	outed ad ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of	:							
8760,	icate be executed physician and the burial-transit	dicat Exa	resulting in death) Last	Due to (or as a	consequence of								
9	ificate g phy as the	edic		U									_
O. Box	that the death certifica ed by the attending pt detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ♣No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at to 9 □ Unknown	Fetal death	3 ☐ Ectopic pi 5 ☐ Other (sp				_	23d. Date of de Month	ivery Day Year	
٩			Part II. Other significant conditions	contributing to death but	t not resulting in t	he underlying o	ause give	en in Part I.	23e. i	Did tobacc	use contribute to	the cause of death?	
ds.	uires n sign	d by								1 🗌 Yes	2 ♥ No 3 □ Pr	obably 4 Unknown	
Vital Records	The law requires ate has been sign page 2 should be	ompieted								Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of	
ital	ician: Th certificate ector, pag	e C	25. Was case referred to medical					26. Place o	f Death (Check o		10 103	20110	_
	d is	To B	examiner? 1 ☐ Yes 2 Z No	Hospital: 1 ☐ Inpatien	t 2 ER/Outp	atient 3 DC	Othe	er: 4 🗆 Nurs	ing Home 5K	Residence	6 ☐Other (Spe	cify)	
n of	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Tir		8c. Injury Work	at c?	28d. Desci	ribe how in	jury occurred		
Sio	or: at	atte	2 Accident investigatio			М	1 🗆 1	Yes 2 □ No					
Division	Hospital or Attending 4 hours after death. Funeral Director: After tely filled in by the fune	Certification:	3 Suicide 6 Could not b 4 Homicide determined		ry - At home, farn (Specify)	street, factor	y, office			on (Street r Town, Sta		ural Route Number,	
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	edical (29a. Certifier (Check only one) Certifying Pt 2 Medical Exer	nysician: To the best of miner: On the basis of and manner state	examination and/	death occurred or investigation	at the tim	ne, date and pinion, death	place, and due to occurred at the ti	the cause ime, date a	(s) and manner as nd place, and due	s stated. to the cause(s)	
)	To th Withir	M	29b. Signature and title of certifier	Q1P	, au	> 290	. License	number 36	١ د	29d. [eat. G	h, Day, Year)	
1	11		- Cuun	~ ~ ~ ·		1 1				cc	,	•	_
- 1	0		30. Name and address of person who	completed cause of de		pe, Print)	= Di	sari Su en	apra 1	MD	210	44	ı
	Sta Registr		31. Date filed (Month, Day, Year)	_	ent Pl	ppe, Print) TWY	= Di	oher	phra, 1	MD	210	44	

	1		State of Maryland / De	partment of Health and M	vientai Hygiei	ne a a a c	00000
		For State Registrar		ertificate of Death	Reg.	611110	29802
		. Decedent's Name (First, Middle, Last)		0: /	2. Date of Death Month	Day Year	3. Time of Death
Physicia /Medic		BERNICE	(COLLINS	SEPT,	0 2000	4:45PM
		FA = A M = I		4b. City, Town, or Location of Death	DAR E		11/0
* **				(av) If Under 1 Year If Under 24 Hrs.	8. Date of Birth		N/A place (State or Foreign
Funeral Director				Months Days Hours Min.	SEPT. 20	1919 M/	TRYLAND
	-		10e City Tours	v.) continu	7		10d. Inside City Limits
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289-f	ecto	9ALYLAND CONTROL OF Street and Number	1 14			Citizen of What Cou	ntry?
3E OF	i Di	5303 ETHE	- I BERT AVENU	E 2121	5	451	7.
death	nera	1. Marital Status	5001		pecify Yes or No- to Rican, etc.)		
or Ite		1 Never Married 2 Married	1 ☐ Yes 2 💢 No If Yes, Give	1 ☐ Yes 2 ☑ No Specify:		Specify: Q	1201
hours tural',			nation 16a De	ecedent's Usual Occupation	16	o. Kind of Business/Ir	ndustry
in 72 n "nei n velic	plet	(Specify only highest grade	completed) (C	live kind of work done during most of wor fe. DO NOT use retired)	rking	. 1	11
d with giene. er tha	Com	8 THGRADE	College (1-401-517)	TOME MAKER	ζ	OWN	HOME
be file ital Hy od othe	Be	17. Father's Name (First, Middle, Last)				den Sumame) (U ,	NANGUL
Men Marke Marke	ဍ					itv or Town, State, Zi	n Code)
d 2 st th and th and treun treun		Ω	1/2	X - CX CX 1			and the second second
s 1 an f Heal tem 2 other		20a. Method of Disposition	20b. Place of D	Disposition (Name of	Date 20	c. Location - City or T	own, State
Pages nent of nnt: If It		1 Ø Burial 2 ☐ Cremation 3 ☐ R 1 4 ☐ Donation 5 ☐ Other (Specify)		PHILL PENE 9-1	17-05 K	ALTIMORE	MARYLAND
rmit. spartm porte ly inju		21. Signature of Funeral Service Licens		22. Name and Address of Facility	BROWNC	TR. FUNE	CAL HOME
89 2 2 9		1 withers!	J. Williams	2140 N. 1-ULTO	NAVE,	MALTO, M	02/2/1
		shock, or heart failure. List only of	ne cause on each line.	t enter the mode of dying, such as caldia	c or respiratory a resi		Approximate Interval Between Onset and Death
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Examiner			deubi				lyeor
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oe exe cien a ourial-		resulting in death) Last	Due to (or as a consequence of	j:			
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death e atter	ician	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deli Month	very Day Year
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05-06065 Charles Clark RJD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	_	Registrar 1. Decedent's Name (First, Middle, La	st)		Tuncate of L	Jean	2. Date of De	Reg. No.	05 2980
Physic		CHARLES .		ARK II			Month	Day \	Year
/Medi Exami		4a. Facility Name (If not institution, gire			4b. City, Town, or	Location of Death	Septemb	4c. County of	2005 2357 P. M
LAAIIII	iei	University Hospi			Baltimor				VIA
Funeral		5. Social Security Number 6.	Sex 7. Ag	e (In yrs. last birthday	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir		Birthplace (State or Foreign Country)
Director		215-11-1285 -	20 F	20 Yrs.	Months Days	Hours Min.	APRIL 6	y, Year)	Country) MD
pu 🔹 :		Usual Residence of Decedent 10a. State 10b. County		10a City Town as I	a cation				
with the Marylan a or 28a-1 show be notified at	7	· · · · · · · · · · · · · · · · · · ·		10c. City, Town or L	_				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
the M	Director	MD BA	LTIMORE		Roseda	le			
with a or	٥		Richard .	AT	10f. Zip Code	1237		10g. Citizen of Wh	•
eeth	Funeral	11. Marital Status	12. Was Decedent				northy Von or No		- American Indian.
riter d	표	→ Never Married 2 Married	Armed Forces?	No.	Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black,	White, etc.
tiled within 72 hours after deeth with the Maryland Hyglene. Hyglene. Ither than "natural", or Itams 23a or 28s-1 show int, the Medical Exacting transities notified at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify:	white
72 ho	Completed	15. Decedent's E (Specify only highest gr		16a. Dece	ident's Usual Occupa	ation		16b. Kind of Busi	iness/Industry
thin it	nple	Elementary/Secondary (0-12)	College (1-4or 5	i+)	b kind of work done a DO NOT use retired,)	ng		^
ygler t, tt	S	12-4	NA		CONSTRUC	(100		Self	<u> </u>
be fill tal H d ott	Be	17. Father's Name (First, Middle, Last		,				Maiden Sumame))
should be nd Mental marksd o	2	CHARLES . W				Denis		WERS	
permit. Pages 1 end 2 should be filed within 72 hopermit. Pages 1 end 2 should be filed within 72 hoperment of Heelih and Mental Hyglene. Important: If item 27 is marked other than "netun any fijury or other trsumatic event, the Mudical ORGS.		19a. Informant's Name/Relationship			ing Address (Street a		-		
1 end deelti sm 2 thar i		VENISE BOWERS 20a. Method of Disposition	CLAKK	20b. Place of Disp	ING RIC		KoSe		2/237
Pages nent of I		1⊟Burial 2 ☐ Cremation 3 [cemetery, cre	matory or other place			20c. Location - C	
it. Partitions ritions and any and and any and and any and any and and any any and any and any any and any any any and any any any any any any any any any any		4 Donation 5 Other (Speci		Holly H		W : 1117	1	BAItO. A	4
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		23a Part Enter the disease or con	Tell	VA 17	527 has	FORD FD.	130 Ho. 1	m 2123	9
		23a. Parl 1. Enter the disease, or con sinck, or heart failure. List only	one cause on each lir	ne death. Do not er ne.	ter the mode or dying	g, such as cardiac c	r respiratory a	rest,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a GUNCHOT		of poste	FRIOR TO	RINO		Onsor and Boath
Examiner			Due to (or as	a consequence of):					
N - 10	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence of):					
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cate be executed only siclen and the burial-transit	dicail		đ						
	ed								
The law requires that the death certificate the second of	ician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		75.4			23d. Date	of delivery
deat death	sicia	in the past 12 months?	4☐Pregnant at		□Ectopic pregnancy □ Other (specify)			Month	h Day Year
by the datached	Physi	9 Unknown	9Ll Unknown						
es tha igned be det	by	Part II. Other significant conditions	contributing to death be	ut not resulting in the t	inderlying cause give	n in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?
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The Tate he page	Completed							rmed? dea 2 □ No 1 P	or to completion of cause of ath? MYes 2□ No
	Be	25. Was case referred to medical examiner?				26. Place of Death		100	W162 5 140
nysician; nis certific i director,	2	1 Types 2 □ No	Hospital: 1 X Inpatie	nt 2 ER/Outpatie	nt 3 DOA Othe			lence 6 Other	(Specify)
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tsndli Jeath. tor: A	atic	2 Accident investigation	9/4/05		. M 1 1 7	res 2 No	SVBTE	CT WA	SIHOT
r Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	e 28e. Place of Inju	ury - At home, farm, st	reet, factory, office	4	28f. Location (S	Street and Number	or Rural Route Number,
To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by			STRE	ET		C	HILWORT	HAVE W. OF	FENSLEIGH AVE
Hosp 4 hou Fune ely fil	edicai	(Check chil) SM Manifest Exa	nysician: To the best on miner: On the basis of	of my knowledge, dear	h occurred at the tim	e, date and place, a	and due to the	cause(s) and mann	er as stated.
ths hin 2 ths	Med		and manner sta	ted.					
5 <u>\$ 5</u> <u>8</u>		29b. Signature and title of certifier	· ·		29c. License			29d. Date signed (
		/ yull			0.C.	M.E.		Septembe	er 05, 2005
101		30. Name and address of person who				nn Stract	Ro1+	imoro Mor	ryland 21201
		31. Date filed (Month, Day, Year)	UB10 MI		TII Pe	ani prieet	, Dalt.	more mar	.yıand 21201
St Regist	ate rar	SEP 1 4 2		ar's Signature					
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DHMH 17 Rev 1/2001

			1 - For State Registrar	State of N		nd / Depa		Health and M	-	giene	9161e. 2005	2000
tes.	Physici /Medio Examin	al	1. Decedent's Name (First, Middle 4a. Facility Name (If not institutio		ir)	Co	Lean		2. Date of Do Month Sprem	ber 10	Year	3. Time of Death
* *	Funeral Director		5. Social Security Number 220–12–6551 Usual Residence of Decedent	Oleves Hos 6. Sex 1 M 2 F	Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days		8. Bate of Bi (Month, D. 05/08)	rth 27 1926	Coun	olace (State or Foreign otor) Land
	death with the Maryland ms 23c or 28a-f show	Director	10a. State 10b. County Maryland	N/A		ty, Town or Lo						0d. Inside City Limits
	23e or 2		10e. Street and Number 202 N. Milton	Avenue			10f. Zip Code 21224				of What Coun State	•
0000	after or Ite	by Funeral	11. Marital Status 1 □ Never Married 2 □ Mar 3 ★ Widowed 4 □ Divorced	If Yes Give	No No		Was Decedent of If Yes, specify Cub	Hispanic Origin? (Sp. an, Mexican, Puerto Specify:	ecify Yes or N Rican, etc.)		Race - Americ Black, White, o ecify: Whit	etc.
1215-	within 72 hours . ene. than "natural",	Completed		nt's Education est grade completed) College (1-4c	or 5+)		_	pation during most of work ad)	ing		f Business/Ind	dustry
land 2	uld be filed v lental Hygie rked other t tlc event, th	To Be Co	17. Father's Name (First, Middle, Pete Perera	Last)		HOUSE	ekeeping	18. Mother's Name		Banki , Maiden Sun		
Mary	d 2 shouth and N 7 is mai		19a. Informant's Name/Relations Gina Calcara -					and Number or Rura				
Baitimore, I	Pages 1 and nent of Health Int: If Item 27 Iry or other tr		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (3	3 ☐Removal from Sta	ie I	Place of Dispo cemetery, crea	osition (Name of matory or other pla		Date	20c. Location	on - City or To	
Balt	permit, Page Department Important: If any injury or		21. Signature of Funeral Service	1	1CH		-	ess of Facility Veber Fune Ster Stre				
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. Di La Due to (or	ed the deat line. as a consequence	quence of):		mg, such as cardiac o		arrest,	e	Approximate Interval Between Onset and Death
8760,	icate be executed physicien and sthe burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a conseq	quence of):						
O. BOX 68	death certif e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 \$\frac{1}{2}\$\$ No 9 □ Unknown	23c. If yes, outcor 1 □Live birth 4 □ Pregnant 9 □ Unknowr	2 Feta	al death 3[Ectopic pregnand Other (specify)	y		23d.	Date of delive Month	Pry Day Year
ecords, P	The law requires that the ate has been signed by th bage 2 should be detache		Part II. Other significant conditions of the con	ions contributing to death	fice	2	nderlying cause gr	_		tobacco use c		ne cause of death? ably 4 Monknown
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Division	tal or Atte s after des al Directo ed in by th	Certification:	3 Suicide 6 Could 4 Homicide detern	nined 286. Place of	Injury - At h etc. <i>(Speci</i> l	ome, farm, sti	eet, factory, office		28f. Location City or To	(Street and Nu wn, State)	ımber or Rura	l Route Number,
	To the Hospital or within 24 hours aft To the Funeral Dis completely filled in	Medical	one)	ng Physician: To the be Examiner: On the basis and manner	of examina	owledge, deat ation and/or in	vestigation, in my	opinion, death occurr	and due to the ed at the time	date and place	ce, and due to	the cause(s)
i	or Marie	1	29b. Signature and title of certific	mna		nel	ND DC	x 5891	7	_	gned (Month, L	10, 2005
J	1		30. Name and address of person	who completed cluse of	5 4	m 23a) (Type,	WOLF	EST. F	BAUTI	MON	-MI) 2128-
	Sta Regist		31. Date filed (Month, Day, Year	4 2005 32. Jegi	strar's Sign	ature	all					

DHMH 17 Rev 1/2001

			1- State of Maryland / Dep	partment of Health and Mertificate of Death	ental Hygie	ene 2005	29805
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia		Dorothy L. Ca	ple	Sept 9,	2005 Year	12:53 p M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
		. # ej	Carroll Hospital Center	Westminster		Carrol1	L
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	ear) Cou	nptace (State or Foreign intry)
36	Director		219-14-2197 88	<u> </u>	April 27,	, 1917 Ma	ryland
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Mary f sho	ro.	MD Carroll	Finksburg			1 ☐ Yes 2 No
	the 28a	Director	10e. Street and Number	10f. Zip Code	100	. Citizen of What Cou	untry?
	3s ou		2442 Sandymount Road	21048		U.S.A.	•
	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or flams 23s or 28s-f show event, i'n Medical Examinar must be mollified at	Funerai		Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - Amer	
9	after or its		1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 ☑ No Specify:	ncan, etc.)	Black, White	, etc.
5-0036	ural',	d by	3 X Widowed 4 ☐ Divorced Year or Dates:	TEL 163 ZEL 110 Opecity.		Specify: Wh	nite
<u>7</u>	"nati	Completed	(Specify only highest grade completed) (Given	edent's Usual Occupation re kind of work done during most of working	ng 16	b. Kind of Business/li	ndustry
12.	withir sne. than	m	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) Senior Aide	T7.		g t
2	filed within I Hygiene. othar than "ant, the way		17. Father's Name (First, Middle, Last)	18. Mother's Name			Senior Cnt.
Maryland	ould be Mental arkad o	To Be	Archibald Carroll Blizzard		ie Lavin		
2	s 1 and 2 should be f Health and Menta itam 27 Is marked other traumatic ev	F		iling Address (Street and Number or Rura			ip Code)
	d 2 th a 1 tra			3 5th Avenue Upper		21155	
ē,	s 1 and 2 if Health itam 27 other tra		20a. Method of Disposition 20b. Place of Dis			c. Location - City or T	own, State
Ë	Pages nent of int: If its iry or o		1 Zabanar 2 El Cramation 3 El terriova nom state	ad Cemetery 9/13	/05	Reisterst	own MD
altimore,	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or othar once.		The state of the s			terstown R	
ñ			Stephen M. Jenkins E	LINE FUNERAL HOME R			21136
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or	r respiratory arrest	t,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Later Kilowa	stown		Onset and Death
	/Medical		resulting in death) a	Chaux 2100		•	
	Examiner	_	Sequentially list conditions, b.				O
	D #	Examiner	if any, leading to immediate Due to (or as a consequence of):				
	ecute and -trans	cam	Cause (Disease or injury that initiated events c				
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8760		dicai	d				
9 ×	The law requires that the death certificate has been signed by the attending I agge 2 should be detached for use as	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			Old Date of dall	
Вох	atten for u	Physician/M	in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of deliver Month	Day Year
o.	the d y the Iched	ysi	1 ☐ Yes 2 No 9 ☐ Unknown	Control (openity)	1-2-2-7		
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Records,	quires n sign		Mosel Demestra		1 🗆 Yes	2 2 No 3 □ Pro	bably 4 Unknown
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	The lav te has age 2	Completed			autopsy performe	d? death?	ompletion of cause of
Vita		Be C	25. Was case referred to medical	26. Place of Death		No 1 ☐ Yes	2 No
	Attanding Physician: r death. sctor: After this certificator, the funeral director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 25 FR/Outpati	Other		ce 6 ☐Other (Speci	rfy)
Division of	ding Phys		27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day Year)	of 28c. injury at 2	8d. Describe how		
Ö		atic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
<u> </u>	l or Attanatter deat Diractor:	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 2	28f. Location (Stree City or Town, 5	et and Number or Rui State)	al Route Number,
	ital o	Cer					
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	To tha Hospital or At within 24 hours after or To tha Funaral Diraci completely filled in by	Med	one) and granner stated. 29b. Signature and title of pertifier	29c. License number		. Date signed (Month,	
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•	161		30 Name and address of any 1	185044	9	ela 154	, and
	1		30. Name and address of person who completed cause of death (Iten 23a) (Typ	e, mint)	4.	1.0.	- 1/10 (
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State of Maryland / Department of Health and Mental Hygiene 29806 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year VIRGINIA LOUISE CATE 3:30 p. /Medical September 7,2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Timonium 2202 Dalewood Road If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 8. Date of Birth Month, Day, Year 917 Feb. 25, 1917 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2√2F 88 Virginia 225-22-1099 Director Usual Residence of Decedent 10c. City, Town or Location "natural", or Items 23a or 28a-f show 10d. Inside City Limits Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director **Maryland** Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2202 Dalewood Road 21093 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ģ 1 ☐ Yes 2 No Specify: Specify: 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other then eny Injury or other trainmain. Elementary/Secondary (0-12) College (1-4or 5+) 5+ years Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sisson Roxy Simpson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David M. Evans (Son) 7900 Elmhurst Ave. Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 9-12-05 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Mitchell-Wiedefeld F.H. Inc.
6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) meta Physician 10a18 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) igned by the attending physician and be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has this certificate Be 25. Was case referred to medical examiners 26. Place of Death (Check only one) Other: 4 Nursing Home 2 No ဥ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) funeral 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred Certification: Natural 5 Pending death. 1 Tyes 2 No 2 Accident investigation the Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Dire Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Redical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check or one) 29b. Signature and little of certifie 29c. License number 29d. Date signed (Month, Day, Year) 1) a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		1 - For State Registrar	State of Marylan	•	tificate of I		Re	g. No. 200	
Physicia /Medic		Decedent's Name (First, Middle, Last) ILENE	D.		СОН		2. Date of Death	ER ^{ay} 10, 20	3. Time of Death 05 4:20 A M
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Funeral Director		5. Social Security Number 6. Sep 1 C C C C C C C C C C C C C C C C C C	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, JULY 5,	1962 ^{9. Bi}	rthplace (State or Foreign Country) MD
Maryland -f ehow	tor	10a. State 10b. County MD BALTI		y, Town or Lo				<u> </u>	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
h with the 23a or 28a at be noti	Funeral Director	10e. Street and Number 1800 TRENLEIGH RO			10f. Zip Code	21234	10	g. Citizen of What C	Country?
be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "neturel", or Iteme 23a or 28a-f show event, the Madical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2(※) Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 🂢 No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ※ No	ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
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Page: nent o ant: If ury or		20a. Method of Disposition 1 A Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungral Service Licens.	lemoval from State	REW YO		CEM. 09/12	2/2005	WOODLA	WN, MD
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		•	State of Maryland / Department of Health and Mental Hygiene 2005 29809 Certificate of Death Rag. No. 2005
	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 3. Time of Death Month Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death c
	Funeral Director	8 ·	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 1XI M 2 F 86 Yrs. 86 Yrs. Sept. 14, 1918 MARYLAND
	t 28a-f ehow	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE 1 XYes 2 □ No
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-0036	hours after des turel', or Items al Examiner m	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Was Decedent Ever in U.S. Armed Forces? 16. Yes, specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Race - American Indian, Black, White, etc. 17. Was Decedent Ever in U.S. Armed Forces? 18. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 18. Race - American Indian, Black, White, etc.
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VeC	ges 1 and 2 s t of Health ar If Item 27 is or other trau		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROLYN DRIVER CUNNINHGAM/Daugh. 423 Acadia Dr. Perry Hall, MD 21128 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 1 XBurial 5 Collins (Sum of Constant) 1 XBurial 7 Collins (Sum of Constant) 1 XBurial 8 Collins (Sum of Constant) 1 XBurial 9 Collins (Sum of Constant) 1 XBurial 9 Collins (Sum of Constant) 1 XBurial 9 Collins (Sum of Constant) 1 XBurial 9 Collins (Sum of Constant) 1 XBurial 9 Collins (Sum of Constant) 2 XBurial 9 Collins (Sum of Constant) 1 XB
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	Physician /Medical Examiner		Approximate Intervite disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Onset and Death Due to (or as a consequence of):
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	[T]		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
er A	Sta Registi		Dr. Mythili Murthy Benderson 9000 Franklin Square Drive Baltimore, MP 21237 31. Date filed (Month, Day, Year) SEP 1 4 2005 Benderson 9000 Franklin Square SEP 1 4 2005

State of Maryland / Department of Health and Mental Hygiene 2005 For State Registra 298 I N Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year SEPTEMBER 9, 2005 **Physician** Mary Sadie Dibley 12:15A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Saint Joseph Medical Center Towson 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sex **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 □ M 2 🖫 F 90 New York 094-01-7068 Director July 25, 1915 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow traumatic avent, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Maryland Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 3923 Link Avenue 21236 U.S.A. Itema 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 □ Divorced "natural", 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clothier Manager Clothing Retail 12th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 is marked othin any lipiny or other traumatic event 2008. Be Filippo Cipolla Filippa Gull.o 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Michele Silwick (dghtr) 3923 Link Ave., Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 9/14/2005 Baltimore. Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sports See 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death trimediate Cause (Final disease or condition resulting in death) Pnysician DAYS PNEUMONIA /Medical Due to (or as a consequence of): Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit or Attanding Physician; The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760, sicien Be Completed by Physician/Medical the for use es IF FEMALE: 23c. ff yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0 been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s 1 ☐ Yes 2 No Division of Vital 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitaf: 1 ☐ Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. fnjury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Naturaf 5 Pending after death. 1 Yes 2 No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide filled in I within 24 hours a To the Funeral C completely filled i 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number M.D. Lou, ptember 9 D 17695 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 DELER DRIVE TOWSON MARYLAND 21204 eBDeLLeH J. RELOU M. D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

		1	For State Registrar	State of Marylar	nd / Depa	artment of I	lealth and			005	29811
	Physicia /Medic	al .	1. Depedent's Name (First, Middle, Las	Jestle	()	Davi	d	2. Date of De Month	Ë	ŏ35	3. Time of Death
	Examin Funeral Director		4a. Facility Name (If not institution, lorge Balfi More VA 5. Social Security Number 6. So 215 30 4504	Medicalli	2ner . last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H	rs. 8. Date of Bird	th y, Year)	9. Birthpl Coun	ace (State or Foreign
	Marylend a-f show	tor	Usual Residence of Decedent 10a. State 10b. County M.I) M.II		BAIfima					10	0d. Inside City Limits 1 2 Yes 2 □ No
	ath with the	rai Director	10e. Street and Number 2578 Mances	54		10f. Zip Code	,		45		
980	hours after death with the Marylend lurel; or Items 23a or 28a-f show at Experit at must be codified at	by Funeral	11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Decedent Ever in I Armed Forces? 1 ☑ ¥es 2 □ No If Yes, Give Year or Dates: / 953		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☐ No		(Specify Yes or No erto Rican, etc.)		Race - America Black, White, on Cify:	etc.
21215-0036	within 72 ane. than "nai	Completed	15. Decedent's Ed (Specify only highest gra	ucation	16a. Dece	dent's Usual Occu kind of work done DO NOT use retire	during most of w	vorking		Business/Ind	
Maryland	should be filed and Mental Hygie marked other umatic event.	To Be C	17. Father's Name (First, Middle, Last) Wash David 19a. Informant's Name/Relationship (7)	Suna Print)	10h Maili	ng Address (Street	Charoles	ame (First, Middle, Fr DUV) C Rural Route Number	Maiden Sun	name)	
	Pages 1 and 2 sho nent of Health and int: If Item 27 is mu iry or other treumi		DEAFNICE DON'T 20a. Method of Disposition 1 Strial 2 Cremation 3 D	206.	252 Place of Dispo	Sition (Name of matory or other pla	ES 54	BAI fine	20c. Location	J/2/ on - City or To	7 wn, State
Baltimore,	permit. Pages Department of Important: If I any injury or once.		*4 Donation 5 Other (Specify 21. Signature) of Funeral Service Licen) (6	ALLISON 2	TOCES A CA	ess of Facility	15/05 Bests Funer, Bestsmo	pi Hor	ne	
	Physician /Medical		23a. Part1. Enter the disease, or comp. shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	Dilications that caused the dealer one cause on each line. a. And XiC Due to (or as a conse		ter the mode of dyi	ng, such as card				Approximate Interval Between Onset and Death 8 days
	Examiner	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b ASV STONIC Due to (or as a consection of the	carr						3 days
.O. Box 68760,	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	tal death 3	□Ectopic pregnanc □ Other (specify) _	у			Date of delive Month	ry Day Year
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of Vital Records,	The ate h page	e Completed by	25. Was case referred to medical					1 Tes	osy ormed? 2 🛣 No	prior to con death?	bsy findings available inpletion of cause of 2 No.
	ding Phys n. After this funeral di	To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpaties 28b. Time o Injury	f 28c. Inju	ner: 4 Nursing	Home 5 Resi	dence 6 🗆)
Division	i Life	Certification:	3 Suicide 6 Could not be determined	building, etc. (Spec	eify)			City or To	wn, State)		Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	29a. Certifier (Check only one) 1	ysician: To the best of my kniner: On the basis of examinand manner stated.	nowledge, deat nation and/or in	h occurred at the ti vestigation, in my	opinion, death oc	curred at the time,	date and plac	manner as sta ce, and due to gned (Month, L	the cause(s)
, /			MA	1 Ami	D.	P	18814		_		2005
4	100			completed cause of death (Itemselve ST. Ba	1timo	re, mo	213	701			
	Sta Regist	1		2005 Magistar's Sign	, A.	Sperker					

		_	1 - For State Registrar	State of N	Maryland / [Depa <i>Cer</i>	rtment tificate	of He	ealth a Death	and Me	ental Hyg	giene 2	005	29812
	Physici	an	Decedent's Name (First, Middle, L							2	. Date of Dea Month	athDay	Year	3. Time of Death
	/Medic	al		SERFIELD		- 1	45-03-7				sep.	7, 2	1005	1600 M
	Examin	er	4a. Facility Name (If not institution, g	/			4b. City, T	fines		f Death	•	4c. Coun	ty of Death	
	: Francisco		UNION MEMURICAL 5. Social Security Number 6.		/ Age (In yrs. last bir	thdav)	If Under		If Under a	24 Hrs. 8	B. Date of Birt	h	9. Birthr	place (State or Foreign
	Funeral Director		219 26 6529	1 2 M 2 F	10	Yrs.	Months	Days	Hours	Min.	(Month, Day	7. Year) 3. 193/	Cou	ntry)
	ס		Usual Residence of Decedent				1	1			344	1117		
	how how	_	10a. State 10b. County		10c. City, Tow								1	10d. Inside City Limits
	Ba-f	잃	M.D N/a		BA HI	more								1 ☑ Yes 2 ☐ No
	ith th	5	10e. Street and Number				10f. Zip					10g. Citizen of	-	ntry?
	s 23s	Funeral Director	5117 Kenwood AV			140.11		1206			, M	4.5	<u> </u>	and the disease
	er de	in l	11. Marital Status 1 □ Never Married 2 ☑ Married	12. Was Decede Armed Force 1 2 yes 2	s?	13. V	Yes, speci	ent of His ify Cubar	spanic Ong n, Mexican	gin? (Spec i, Puerto Ri	fy Yes or No- can, etc.)	- 14. Ha	ace - Americack, White,	
36	irs of	b.	3 Widowed 4 Divorced	If Yes, Give Year or Date	s:1955-1956	1	☐ Yes 2	.□•46	Specify:			Spec	ity: Bl	CIE
21215-0036	iliad within 72 hours eiter deeth with the Maryland Hyglene. ther than "natural", or Items 23a or 28a-f ehow ther than Micdical Examinational be inclified at	ed ed	15. Decedent's	Education		. Deced	ent's Usual	Occupa	tion			16b. Kind of I		
215	Pin 7	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College/(1-4d	or 5+)	lite. E	kind of worl OO NOT use	k done di e retired)	uring most	t of working				
21	glen than	5	18	0	0	KE4.	ER C	ARLIE	R			U.5 P	stol.	SERVICE
pu	al Hy	Be	17. Father's Name (First, Middle, La	st)					18. Mothe	r's Name (First, Middle,	Maiden Suma	ime)	
yla	should be ind Mental is marked o	၉	ddward Danger	reld							PARKIS			
Maryland	s 1 and 2 should be filed within 72 hours effer deeth with the Marylen if Heelth and Mental Hyglene. Item 27 is marked other than "natural", or Items 23a or 28a-f ehow other traumatic event, the Madical Examiliner Livial Lie Indiffied at		19a. Informant's Name/Relationship	(Type, Print)			-					er, City or Town		
	1 end Heelth em 27 ther tr		20a. Method of Disposition	genfield	20b. Place of	f Dispos	sition (Nam	e of	od Av	E Da	MHIMI	20c. Location	- City or To	6 Dum State
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Baltimore,			4 □Donation 5 □ Other (Special Service Licenses) 4 □ Donation 5 □ Other (Special Service Licenses)		CARRISE.	22	Name and	Addras	s of Facility	1/16/	05	BATTINA HO	MORE V	
Ba	permit. Departr Importa any inju		Yatucia &	Bett		1/						hwite v		
			23a. Part1. Enter the disease, or co	mplications that cau	sed the death. Do	not ente	-	<u></u>					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Approximate
	Physician		shock, or heart failure. List on fmmediate Cause (Final	and the same of th										Interval Between Onset and Death
	/Medical		nmediate Cause (Final sease or condition sulting in death) Due to (or as a consequence of):											
	Examiner		Sequentially fiet conditions	uentially fist conditions, y, leading to immediate b. End Stage Teres Disease Due to (or as a consequence of):										
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Box (certif nding use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom				_				23d D	ate of delive	arv
	death e etter	clar	in the past 12 months?		1 2 □ Fetal death t at time of death		Ectopic pre Other (spe					1	lonth	Day Year
P.O.	requires that the death een signed by the etter hould be deteched for u	hys	9 Unknown	9□ Unknowr	1 —									
	s tha	oy P	Part II. Other significant conditions	contributing to deat	h but not resulting i	n the ur	nderlying ca	use give	n in Part I.		23e. Did to	obacco use co	ntribute to t	he cause of death?
pro	w require been sl	pe	Typez Diche	tes her	11705						101	res 2 □ No	3 🗌 Prob	ably 4 Denknown
ecc	> 0 0	ple	Hypertensier	a							24a. Was autop		. Were auto	psy findings available mpletion of cause of
<u> </u>	The sete he pege	Completed by									perfo	202 No	death? 1 ☐ Yes	21 No
Division of Vital Records,	Physician: The lev this certificate hes rel director, page 2	Be	25. Was case referred to medical examiner?	114-144				101		of Death (Check only o	ne)		
of	Physl this o	၉	1 ☐ Yes 2 ☑ No 27. Mannar of Death		atient 2 ER/OL	tpatien			4 🗆 Nu			lence 6 🗆 O		(y)
L C	After After funer	lo	1 1 Natural 5 ☐ Pending	28a. Date of I (Month,	Day Year)	Injury	M Z	Bc. Injury Work	al ? ′es 2.⊟/		d. Describe r	now injury occu	nrea	
isi	Attending r death. ector: After by the fune	lical	3 ☐ Suicide 6 ☐ Could not	be On Diagon	Injury - At home, fa	arm. stre			03 2		f. Location (5	Street and Num	ber or Rura	al Route Number,
⋛	efter efter Dire	Certification;	4 ☐ Homicide determine	building	etc. (Specify)			,			City or Tox			
	Hospitel 24 hours 6 Funeral 1ely filled	<u>a</u>	29a. Certifier 1 Certifying	Physician: To the be	est of my knowledge	e, death	occurred a	at the time	e, date an	d place, an	d due to the	cause(s) and n	nanner as s	tated.
	To the Hospitel or Attending Phy within 24 hours effer death. To the Funeral Director: Affer thi completely filled in by the funerel	Medical	(Check only 2 Medical Ex	arniner: On the basi and manner	s of examination an stated.	nd/or inv	estigation,	in my op	inion, deat	th occurred	at the time,	date and place	, and due to	the cause(s)
	withi To t	Σ	29b. Signature and title of certifier				29c.	License	number			29d. Date sign		Day, Year)
)	1		1 700	M	0			Doc	5505	6		7)7)09		
(11/1		30. Name and address of person wh	no completed cause	of death (Item 23a)	(Туре,	Print)		6					
			31. Date fifed (Month, Day, Year)	1600 W	of death (Item 23a)	204	cl A	رو	15c 14	WD	21	217		
40	Sta Regist	ate rar		nn5	istrai s Signature	A STATE OF THE PARTY OF THE PAR	San Barrell							
			SFP 1 4 2	JUJ Julian	the state of	450								

7. Age (In yrs. last birthday)

81

9. Birthplace (State or Foreign

9:45 PM

Physician /Medical **Examiner**

4a. Facility Name (If not institution, give street and number) Stella Maris 5. Social Security Number

10a State

4b. City. Town, or Location of Death Timonium

Vrs

4c. County of Death Baltimore

Funeral Director

27 is marked other than "natural", or iteme 23a or 28a-f show treumatic event, the Medical Extending mark to notified at treumatic event, the Medical Extending mark to notified at Be Completed by Funeral Director

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Examiner

Physician/Medical

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Completed

Be

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Certification:

Medical

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Registrar

1 ☐ M 2 👿 F 218-18-6709 Usual Residence of Decedent 10b County

Baltimore

10c. City, Town or Location

8. Date of Birth
(Month, Day, Year)
Sept. 26, 1923 Maryland 10d. Inside City Limits

White Marsh 10f. Zip Code

1 ☐ Yes 2X No

1 ☐ Yes 2 X No 10g. Citizen of What Country?

10e. Street and Number 5308 Bush Street

Maryland

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married

21162 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

If Under 1 Year | If Under 24 Hrs.

Hours

Days

14. Race - American Indian, Black, White, etc.

White

3 X Widowed 4 □ Divorced

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) ning most of working

16b. Kind of Business/Industry

U.S.A.

Specify:

Elementary/Secondary (0-12) 12th Grade

Manager

Mobile Home Park

17. Father's Name (First, Middle, Last)

Charles Nies 18. Mother's Name (First, Middle, Maiden Sumame)

Aleathea Jenkins

19a. Informant's Name/Relationship (Type, Print) Ms. Sandra Evering

(daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2916 Berwick Avenue, Baltimore, MD 21234 20c. Location - City or Town, State

20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify)

Bayview Crematory 9/13/2005

Baltimore. Maryland

Approximate Interval Between Onset and Death

Year

21. Signature of Funeral Service Licensee

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236

Physician /Medical Examiner

nding physicien and use as the burial-transit

use

this certificate

After th

The law requires that the death certificate be executed

Box 68760.

Records, P.O.

Vital

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Division

or Attending Physicien:

hours after death. filled in by the f

within 24 hours a To the Funerel I

LOTTIE EVERING

1 and 2 should be Health and Mental

item 27 is other tre

Importent: If it, any injury or o once.

SEPTEMBER 11,2005

Baltimore,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediate Cause (Final

disease or condition resulting in death)

_ a.	CEREBROVASCULAR ACCIDENT
	Due to (or as a consequence of):
b	
	Due to (or as a consequence of):

Due to (or as a consequence of)

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 X No 9 Unknown

23c. If yes, outcome of pregnancy 2 Fetal death 4☐Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Dav

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

TIMONIUM, MD 21093

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 🗌 Yes 2X No 24b. Were autopsy findings available prior to completion of cause of death? 1 Tes 2 \(\text{No.}

26. Place of Death (Check only one,

Other: $_{4}\square$ Nursing Home $_{5}\square$ Residence $_{6}\mathbf{X}$ Other (Specify) **HOSPICE**

1 Yes 2 No 27. Manner of Death

4 Homicide

1 XNatural 5 Pending investigation 2 Accident 3 ☐ Suicide 6 Could not be determined

25. Was case referred to medical

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

28c. Injury at Work? 28b. Time of 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year) State

4 2005

2300 DULANEY VALLEY RD. 32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			_	•	epartment of Health and		9	
		•	1 - State Registrar	· ·	Certificate of Death		No. 200	5 29814
- 15. - 15. - 15.	Physicia /Medic	al	1. Decedent's Name (First, Middle, Last) James D. Felmer			2. Date of Death Month August 15		3. Time of Death 3:30 p M
	Examin		4a. Facility Name (If not institution, give single Section 1) 524 N. Charles Stre		4b. City, Town, or Location of Deat Baltimore	1	4c. County of Deat	h
	Funeral Director		5. Social Security Number 6. Sex 1점	7. Age (In yrs. last birt		8. Date of Birth Month Day, Y June 3, I	9. Birti 929 Mary	hplace (State or Foreign untry) 1and
	death with the Maryland ms 23s or 28e-f show r must be notified at	ctor	Usual Residence of Decedent 10a. State 10b. County MD	10c. City, Town				10d. Inside City Limits 11 Yes 2 □ No
	with th	Director	10e. Street and Number		10f. Zip Code		. Citizen of What Co	untry?
	should be filed within 72 hours after death with the Marylan told Marylan and Mental Hygiene 1. The marked other than "natural", or flems 23s or 28e-f show marked other than "natural", or flems 23s or 28e-f show market event, in Maryles Examinar must be notified at	by Funeral	524 N. Charles Stre 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	eet #714 2. Was Decedent Ever in U.S. Armed Forces? 1 ★Yes 2 □ No If Yes, Give Year or Dates: \$50-52	21201 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1		14. Race - Ame Black, White Specify: whi	e, etc.
'n	within 72 hou ene. than "natura i e Medica E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation 16a. Completed) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)	rking	b. Kind of Business/	Industry
21	filed with Hygiene other that	Соп	12 17. Father's Name (First, Middle, Last)	4 ma	ke up & designer	ne (First, Middle, Ma	ales & se	rvice
auc	should be fand Mental Famerked of	To Be	Calvin D. Felmer			herine Ber		
ary	2 0 0 2	-	19a. Informant's Name/Relationship (Typ	pe, Print) 19b.	Mailing Address (Street and Number or Ri			Zip Code)
	Health Health tem 27 other tr		Rosalie Carr/execut		O Ingleside Avenue			
Baltimore,	ment of Pages tant: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☑ Donation 5 ☐ Other (Specify)	SHOVAL HOLL STATE	Disposition (Name of y, crematory or other place)		lc. Location - City or	
Ba	permit. Page Department of Important: If any injury of onca.		21. Signatur Coneral Service Licenses	Male	State Anatomy Board Baltimore, MD 2120	<u>l</u>		Street
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rds, P.	w requires that the de been signed by the e should be detached f	by	Part II. Other significant conditions con	tributing to death but not resulting in	the underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Division of Vital Records,	n: The law re licete has bee r, page 2 sho	Completed					prior to d	topsy findings available completion of cause of 2 No
ž	ysicie s certii directo	To Be	25. Was case referred to medical examiner? 1 Tes 2 No	ospital: 1 Inpatient 2 ER/Ou	Othor	th Check on one	ce 6 □Other (Spec	2/64)
ion of	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificete his completely filled in by the funeral director, page		27. Manner of Death 1 Natural 5 Pending Accident investigation	28a. Date of Injury 28b. T	ime of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how		ary)
Divis	lef or Atte s after de ei Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28f. Location (Stree City or Town,	et and Number or Ru State)	iral Route Number,
	To the Hospitef within 24 hours a To the Funerei C completely filled	edicai	29a. Certifier Certifying Physical Country (Check only one)	sician: To the best of my knowledge ner: On the basis of examination and and manner stated.	, death occurred at the time, date and place d/or investigation, in my opinion, death occu	, and due to the cau irred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
)	To T To t	Σ	29b. Signature and title of certilier		29c. License number	9-	Date signed (Month	^
			30(N) e and address of Pirson who co	NPINEM MO	Type, Print) W Rolling U	MURALLY	1 Born	SULL
1	Sta Regist		31. Date filed (Month, Day, Year) SEP 1 4 200	32 Registrar's Signature	Garle			

Please Type or Brint in Black Indelible Inko Finsus 441 Conject Aret Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Yeer September 10, 2005 MARGARET CAROL FARLEY 1:45 a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c QueenPoAnne's 55 Prospect Bay Drive West Grasonville -Queen Anne If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 X Nov 4, 101-26-9147 70 New York Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Queen Anne's 1 ☐ Yes 2 ☐ No Grasonville en Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 55 Prospect Bay Drive West 21638 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🖾 🗛o Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 3 years Elementary/Secondary (0-12) Registered Nurse Public Health 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward A. Monahan Catherine C. Reagan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code)

Prospect Bay Drive West James E. Farley, Jr. / spouse Drive Grasonville, Maryland 21638 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 🖾 Removal from State St. Peter & Paul's Elmira, New York * 4 ☐ Donation 5 ☐ Other (Specify) 09/16/05 21. Signature of Fune 22. Name and Address of Facility
Donaldson Funeral Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 23a. Part1. Enter the disease, shock, or heart failure. Lis r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cance disease or condition resulting in death) Ung Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ ₩o 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑No 1 Yes 2 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital:

Physician /Medical Examiner The law requires that the death certificate be executed

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

28a-f show

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Completed by Funeral

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

Attending Physician:

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certificate

Examiner Physician/Medicai Completed by To Be

use as the burial-transit been signed be should be detailed pege 2 director, After thi funeral Certification: in by

IF FEMALE:

1 ☐ Yes 2 ☐No 27. Manner of Death 1 S Natural 5 Pending 2 Accident 3 ☐ Suicide

6 Could not be determined

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred

 Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certified

29c. License number 032036

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

much 30. Name and address of person tho completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) State 1 4 2005 Registrar

4 Homicide

29a. Certifier

32. Agistrar's Signature

D. Donato Ding Chesher.

O5-06079 James Fogle

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	S		1 - For State Registrar	State o	of Marylar			of Health of Deat		lental Hyg	giene Neg. No.	2005	298	16
	Physici		Decedent's Name (First, Midd TAMES: D.T.CHER	,						2. Date of Dea Month Septemb	ith Day	5, 2005	3. Time of Dea 15:55	th M
£	/Medio Examir		JAMES RISHEI 4a. Facility Name (If not institution 3330 Henry G. 1	n, give street and nu		1e	4b. City, To	own, or Location	on of Death	beptem		County of Death	10:00	
Ī	Funeral Director		5. Social Security Number 250-58-3288	6. Sex 1 → M 2 □ F	7. Age (In yrs.	last birthday)			der 24 Hrs.	8. Date of Birth (Month, Day Aug 14,	, Year)	9. Birth	olace (State or For htry) th Caro1	
	B Maryland B-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Howar	d County		ty, Town or Lo							0d. Inside City Lin	mits
	th with th	al Director	10e. Street and Number 5371 Harpers	Farm Road			10f. Zip 0	2104 ⁴	4		10g. Citize	en of What Cou	ntry?	
036	be filed within 72 hours efter deeth with the Maryland ital Hygiene. Id other than "naturel", or iteme 23a or 28a-f ehow event, the Madical Examinar must be maillied at	by Funeral	11. Marital Status 1 Never Married 2 Mai 3 Widowed 4 Divorce	rried 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2 □ No ve		Was Deceder If Yes, specifi 1 ☐ Yes 2			ecify Yes or No- Rican, etc.)		4. Race - Americ Black, White, Specify: Whi	etc.	
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yland 2	2 should be filed withir and Mental Hygiene. Ie marked other then aumatic event, the Ma	To Be Co	17. Father's Name (First, Middle, Frank R. Fogle				Inspec	18. Mo	ther's Name	(First, Middle, James	Maiden Si		reareare	
_	1 end 1eelth em 27 ther tr		19a. Informant's Name/Relation: Melvin W. Fogle 20a. Method of Disposition		ther)	542 Place of Dispo	Snapo	lragon	Street	Route Number, Cope,	Sou		lina 290	38
altimore,	permit. Pages Depertment of I Important: If Ite any injury or of		1 M Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3 21. Signature & Funered Service	Specify)		2	gee Bp	t. Ch (cility			geburg,		
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	To the comp	W	29b. Signature and title oncertific	Anx	M			O.C.	M.E.			signed (Month, ember 06		
-	13			36AN		111	Print) Penn	Street,	Balt	imore,	Mary1	land 212	201	
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		í	For State Registrar	State of Maryland /	Department of H Certificate of I	lealth and M <i>Death</i>	lental Hygien Reg. N	°2005	29817
			1. Decedent's Name (First, Middle, La	ist)			2. Date of Death		3. Time of Death
	Physicia /Medic		Terreu		GORMAN	√ <u> </u>	Sept 12	2005	8215 PM
	Examin	er	4a. Facility Name (If not institution, gi		4b. City, Town, or	Location of Death	4	c. County of Death	,
	Funeral	-		Sex 7. Age (In yrs. last b	pirthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		place (State or Foreign
	Funeral Director			M 2□F 68	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, Yea Dec 4, 19	36 Pen	INSVIVINIA
	pur		Usual Residence of Decedent 10a. State 10b. County	10c City To	wn or Location				
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	r 28a-	Director	10e. Street and Number	K DA	101. Zip Code	,	10g. C	itizen of What Cou	ntry?
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	tems	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
36	within 72 hours after deeth with the Marylan jiene. rithan "natural", or items 23a or 28a-1 show If o Medical Exportment be confified at	byF	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 💆 Divorced	1 Byes 2 No AIR If Yes, Give Year or Dates: Fo Rec	1 ☐ Yes 25 No	Specify:		Specify: [hite
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	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: Atter th completely filled in by the funeral	Me	29b. Signature and title of certifier	. 0	29c. License		29d. D	ate signed (Month,	Day, Year)
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		4	For Stata Registrar	State of Mar		epartment of F Certificate of			iene 20	05 29818
			Decedent's Name (First, Middle, La.	st)			<i>-</i>	2. Date of Dea	th	3. Time of Death
4	Physicia /Medic		Edward McKeenz	ie Gray				Septemb	4, B, 20	9:30pm
	Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o	or Location of Death		4c. County o	f Death
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	Funeral Director		225-66-7382	9X 7. Age (1	In yrs. last birt	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 01/08,	/1948	9. Birthplace (State or Foreign Country) VA
land	* *		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town	or Location				10d. Inside City Limits
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ath w	123e	raic	7786 Fox Cour			21122			U.S.A.	
:1215-0036 within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23e or 28e-f show important: If item 27 is marked other then "natural", or item 23e or 28e-f show any injury or other traumatic event, the Mcdical Examiner out the nutilitied at ange.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🌠 Divorced	12. Was Decedent Even Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	er in U.S.	13. Was Decedent of H If Yes, specify Cub 1 Yes 2 No	an, Mexican, Puerto	pecify Yes or No- Rican, etc.)		- American Indian, , White, etc. White
21215-0036 ad within 72 hours af	natura licat E	Completed	15. Decedent's E (Specify only highest gra		16a.	Decedent's Usual Occup (Give kind of work done	pation during most of work	kina	16b. Kind of Bus	iness/Industry
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and	red of	Be c	Amul Gray	,				d Will		7
Maryland	mark mark	은	19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Address (Street				State, Zip Code)
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. Bo	ed by the attending posterior detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1☐Live birth 2 4☐Pregnant at tir 9☐ Unknown	Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	y		23d. Date Mont	of delivery th Day Year
_ =	igned by be detac	by Ph	Part II. Other significant conditions	contributing to death but	not resulting in	the underlying cause gr	ven in Part I.	23e. Did to	bacco use contrib	bute to the cause of death?
ords,	on sign	ed b	tailure TO Ir	will.				1□Y	es 2 🗷 No	3 Probably 4 Unknown
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- Re	ate ha	Com						perfor	med? de	eath?
of Vita Physician:	certificate rector, pag	Be (25. Was case referred to medical examiner?				26. Place of Dea	th (Check only or	10)	
Of \	W 70	9	1 ☐ Yes 2 🕱 No	Hospital: 1 Inpatient		tpatient 3 DOA			ence 6 Other	
	After funer	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	/ear) 280. I	, ,	ryat irk?]Yes 2 □No	28d. Describe h	ow injury occurre	d
i i	after death. Director: Ai I in by the fu	ertification:	2 Accident investigation 3 Suicide 6 Could not to 4 Homicide determined	De Blace of Injun	y - At home, fa (Specify)	rm, street, factory, office		28f. Location (S City or Tow		r or Rural Route Number,
spita	within 24 hours after deat To the Funeral Director: completely filled in by the	edicai C	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	hysician: To the best of miner: On the basis of e and manner state	xamination an	, death occurred at the ti	ime, date and place, opinion, death occur	, and due to the orred at the time, o	ause(s) and man date and place, ar	ner as stated. nd due to the cause(s)
Tothe	vithin 24 I To the Fu completely	Me	29b. Signature and title of certifier	Medical D	octor	29c. Licen	se number +5148	Ś	29d. Date signed	(Month, Day, Year)
1	71		3 Norm and ad less of person who		th (Item 23a) (10UN TAI)	Type, Pint)	Pasudoni	2 Mui	gland,	21122
	Sta Regist		3 Date filed (Most Day 1 ear) 2	005 32. Fegistrar	s Signature	Coule			/	
DHMH	17 Rev 1/2	001								
				-	ORIG	GINAL				

State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar 29819 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** Hightower Jean 2005 9 1330 Betty /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA 678 E. 27th Street Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day,)
3-1-35 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min Months Days Hours 217-34-6023 1 M 2 XF Yrs. Director Va. 70 Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at Yos 2 □ No Baltimore Director ЬM NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 21218 USA 678 E. 27th Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 ō 1 ☐ Yes X☐ No Specify: Specify: þ Black 3 ☑ Widowed 4 ☐ Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Peges 1 end 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other then? Elementary/Secondary (0-12) College (1-4or 5+) Nursing Home Dietian 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ruby Lynch ပ traumatic Roosevelt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5431 Whitridge Rd., Baltimore, Md. 21206 Son Tony Hightower other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Peges Department of Important: If it any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 9-17-05 4 □ Donation 5 □ Other (Specify) Baltimore, Md. Greenmount Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARCH FUNERAL HOME-EAST Ave. Baltimore, MD 21202 Bla Warren 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1101 E. North Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial HOUR Physician /Medical Due to (or as a consequence of): Examiner AFTERY DISFASE ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burlal-transit Years Due to (or as a consequence of Box 68760, Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. he Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by eq 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No or Attending Physician: After this certific funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one Other: 4 Nursing Home Statement 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Minner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural
Accident 5 🗌 Pendina within 24 hours efter death.

To the Funeral Director: All completely filled in by the fu 1 Yes 2 No investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number Mace alain Mugues, M.D. 30. Name and address of person who completed to of death (Item 23a) (Type, Print) 3333 NORTH CALVERT ST. #500, BALTIMORE, MD 21218 MARC ALAIN MUGMON 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 4 2005 Registrar

		-	For State	State of Maryl		irtment of H tificate of I					
			Registrar 1. Decedent's Name (First, Middle, Last)	, modito of Dodain		2. Date of Deat)5	3 Time of Bear ()	
	Physicia /Medic		BARBARA HOI			SGE		Month 09	Day	ear 5	8:37 AM
	Examin		a. Facility Name (If not institution, give street and number) Bon Secours Hospital			4b. City, Town, or Balto	Location of Death		4c. County of Death		
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Itam 27 is marked other than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show other traumatic event, Ite Madical Extra Instrument to a contact the modified at the modified of the contact that the modified of the contact that the modified of the contact that the modified of the contact that the modified of the contact that t	tor	5. Social Security Number 6. Se 220-38-6588 1	7	vrs. last birthday) 67 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 5-20-	Year) 1938	9. Birthpla Count	ace (State or Foreign ry) Md
			Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10	d. Inside City Limits
			Md N/A Balto ¹₹ Yes 2□No								
		I Director							0g. Citizen of Wh		ry?
36		To Be Completed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever if Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	i	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black,	America White, e	tc.
00-			15. Decedent's Edu	ucation	16a. Deced	dent's Usual Occup	ation		16b. Kind of Busi		
21215-0036			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th grade 15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic Worker 16b. Kind Priv						Private	e Hon	nes
nd			17. Father's Name (First, Middle, Last)	N/A			18. Mother's Name	e (First, Middle, I	Maiden Surname,)	
Maryland	should the ord Ment		Joseph Worthan 19a. Informant's Name/Relationship (T	ivas Print)	10h Mailir	an Address (Street	Queenie		City or Town C	tata Zin	Codol
Na	and 2 sho ealth and n 27 is mu		Queenie Webb - Mc			,	Street A				
nore,	0 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	b. Place of Dispo		ce)	Date	20c. Location - C	ity or Tov	vn, State
Baltimore,	permit. Pag Department Important: I any Injury o		4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Fuer Service License)	,		2. Name and Addre		March F/		COWL	., 110
	20 E 8 0		23a Part 1. Enter the disease, or comp	lications that caused the	death. Do not ent		4300 Wabas				Approximate
¥	ding Physician: The law requires that the death certificate be exacuted The The law requires that the death certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the buriat-transit		23a. Part1. Ehter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Approximate Interval Between Onset and Death Onset and Death								
50,		Physician/Medical Examiner									
			Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or se a cor	Due to (or as a consequence of):						
			that initiated events resulting in death) Last	Due to (or as a consequence of):							
68760,				d							
P.O. Box			IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)						23d. Date Mont		y Day Year
		by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown								/
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Vital			25. Was case referred to medical				26. Place of Deat	1 ☐ Yes h (Check only or	4	Yes	212 NO
of V		ပ	examiner? Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify))	
ouo	ng fter	tlon:	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Yea	ar) 28b. Time o						
Division	To the Hospital or Attending within 24 hours after death. To the Funaral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of City or Town, State)					r or Rural	Route Number,	
J		edical Ce	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
		Med	29b. Signature and title of certifier	and manner stated.		29c. Licens			29d. Date signed		-
	14		20. Name and address of person who completed cause of death (Item 23a) (Type, Print) The SAZEE EDWAND 7001 John Cake Rd nnd 21244								
	<i>a</i> - 01		Mr SBAZEE COMAND 7001 John Cake Rd no 21244								
State Registrar SEP 1 4 2005											

		1	For State Registrar	State of Ma	ryland / De <i>C</i>	partment of F ertificate of	Health and M <i>Death</i>	ental Hygien Reg. N		5 29821	
	Physicia		1. Decedent's Name (First, Middle, Las	2. Date Month				2. Date of Death Month Da	of Death th Day Year 3. Time of Death		
	/Medic Examin	al	4a. Facility Name (If not institution, give	street and number)	Mara	4b. City, Town, o	or Location of Death	September 4	c. County of Deal		
			5. Social Security Number 6. Se	Hosp to	(laura lant hirthe		If Under 24 Hrs.	8. Date of Birth	NA	thologo (Oloto ou Coroina	
	Funeral Director			M 250F 7. Age	(In yrs. last birthd 44 Yrs	Months Days	Hours Min.	10 - 25 - 198	60 Ha	thplace (State or Foreign buntry)	
	/land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	Location				10d. Inside City Limits	
	8a-f sh	Director	ha N/x		Balli	wre				1 XYes 2 No	
	3a or 2		10e. Street and Number 401 E 25 H	st. an	r5K	10f. Zîp Code	21218	10g. C	Citizen of What Co	4.	
	er deati Itams 2 ner mu	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spe pan, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit		
036	ait. Pages 1 and 2 should be filled within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If Item 27 is marked other than "natural; or Itams 23a or 28a-f show injury or other traumatic event, I to Modical Examination untilled at a figury or other traumatic event, I to Modical Examination untilled at 6.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ♣ N If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	Specify:		Specify:	lack	
21215-0036	in 72 h	Completed	15. Decedent's Ed (Specify only highest gra-	de completed)	(G	ecedent's Usual Occu live kind of work done e. DO NOT use retire	during most of working	ng 16b. 1	Kind of Business	/Industry	
	filed with Hygiene. other than	Com	Elementary/Secondary (0-12)	College (1-4or 5	*)	Mixologi			avern		
and	ld be fil ental H ked otl ic even	То Ве	17. Father's Name (First, Middle, Last) Burk Cashy	,		,	Eutha.	(First, Middle, Maide	n Sumame)		
Maryland	2 should n and Men ' Is marke raumatic		19a. Informant's Name/Relationship (7		/	ailing Address (Stree	t and Number or Ryra	I Route Number, City	,		
	s 1 and 3 f Health Item 27 other tr		Eufha A. William 20a. Method of Disposition	m mot	20b. Place of D	sposition (Name of crematory or other pla		ate 20c.	Location - City or	Town, State	
altimore,	perrit. Pages Department of Important: If It any injury or o		1	1)	Trinit	Cem.	Sept	7 2005 B	a/b. l.	d.	
Ba	pernit. Pag Department Important: any injury once.		21. Sign of Funeral Service Licen	Dry Car	/	A. Name and Adda (70) Mc	re look of	Ball	leservit	2 P.A.	
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death disease or condition resulting in death) Breast Cancer with metastasis to liver Spine Due to (or as a consequence of):								
	Examiner		Sequentially list conditions,	Bacteria Due to (or as a consequence of):							
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
60,	ficate be executed physician and is the burial-transit	ai Exa	resulting in death) Last	Due to (or as	a consequence of)						
68760		ledicai		_ d							
Вох	death certifi e attending p d for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown				23d. Date of delivery Month Day Year			
P.O.	0 0 0	hysic	1 ☐ Yes 2 🗹 No 9 ☐ Unknown								
	The law requires ate has been sign page 2 should be	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did to						bacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Vunknown		
ecor		Completed						24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of	
of Vital Records,								performed?	performed? death?		
f Vit	Physician: 'this certifica	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☑Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)							
	ding Ph h. After thi funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?					jury occurred		
Division	ten leat tor: the	Certification:	2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined	e 200 Plans of Ini	ury - At home, farπ c. (Specify)	, street, factory, office		28f. Location (Street : City or Town, Sta		lural Route Number,	
۵	Hospital or A 24 hours after Funeral Dire tely filled in b		29a. Certifier 1 Certifying Ph	nysician: To the best		leath occurred at the t	time date and place	and due to the cause	(s) and manner a	s stated	
	To the Hospital or At within 24 hours after of To the Funeral Direc completely filled in by	Medical	(Check only 2 Medical Examone)	niner: On the basis o	f examination and/	or investigation, in my	opinion, death occurr	ed at the time, date a	ind place, and du	e to the cause(s)	
	To T	2	29b. Signature and title of certifier K - Fyan	K Lu	m.n	29c. Licen	nse number 243894	i6-D8 29d. [Date signed (Mon.	th, Day, Year) 2005	
	0		** K. Frank Lu M.D. AT 2438946-D8 9/11/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kun Fink Lu Union Memorial Hospital, MI Bellinire Na Land 2121								
	St.	ate	Kun K Lu 31. Date filed (Month, Day, Year)	32 Règistr	nion Me ar's Signature _	morial H	ospital,	MD Bo	Himtre	1/a and 2121	
	State Registrar SEP 1 4 2005 32 Registrar's Signature SEP 1 4 2005										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Sadi.e. Hillebrand September 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 3901 Darleigh Road, Unit A Baltimore Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) April 7, 1 9. Birthplace (State or Foreign Country) 1924 North Carolina **Funeral** 1 □ M 2 🔀 F 81 237-30-5620 Yrs. Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3901 Darleigh Road, Unit A "natural", or itama 23a 21236 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White. δ 3. Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene important: If itam 27 is marked othar than "any injury or other traumatic avant the second Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lloyd Demery Doretta Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3502 Thomas Pointe Ct., Unit 3C, Abingdon, MD 21009 Susan Hillebrand (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 4 □ Donation 5 □ Other (Specify) 9/13/2005 Baltimore. Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) myocardia minutes /Medical Due to (or as a consequence of): **Examiner** ronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or as a consequence of) Examine requires that the death certificate be executed burial-transit Division of Vital Records, P.O. Box 68760 that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🗷 No detached the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 1 🗆 Yes 2 No or Attanding Physicien: 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 No P 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification; After 1X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the within 24 hours after death To the Funaral Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of centifie 29c. License number 29d. Date signed (Month, Day, Year) 120034650 person who completed cause of death (Item 23a) (Type, Print) Dr. Jeffrey Cool, 5009 Honeygo Center Dr., Suite 216, Perry Hall, MD 21128 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/200

Registrar

SEP 1 4 2005

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene 2005 29824 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician William M. September 12, 2005 Houck 8:08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Overlea Health & Rehabilitation Ctr Baltimore Under 1 Year | H Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 1**∑**M 2□F 95 216-03-6067 Director 1-05-1910 Baltimore Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits or Itema 23a or 28a-f ehow event, the Mudical Exercicer count be notified at by Funeral Director 1 TYes 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4144 Eierman Avenue S.A. 14. Race - American Indian, 21206 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. I □ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced "natural', White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) 8 Years Cotlege (1-4or 5+) <u>Machinist</u> Western Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be . Pages 1 and 2 should be fil ment of Health and Mental Hi tant: If Item 27 le marked oth jury or other traumatic even Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 925 Rosedale Avenue Baltimore, MD Lawrence C. Simms -Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Date Department of Important: If any Injury or once. Holy Redeemer 4 ☐ Donation 5 ☐ Other (Specify) 9-14-2005 Baltimore, MD 21. Signature of Funeral Service Licensee Charles F. Miner 22. Name and Address of Facility 5305 Harford Road Baltimore, MD Leonard J. Ruck 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): Box 68760 Medical Certification; To Be Completed by Physician/Medical been signed by the attending p should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an page 2 autopsy performed? 2 No 1 ☐ Yes 2XINO Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) No Hospital: Other: 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Ceath 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of gertifier who completed cause of death (Item 23a) (Type 5601-31. Date filed (Month, Day, Year) 32. Regiştrar's Signature State Registrar DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 19:19pm **Physician** John. Hooper September q 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NIA City Baltimore Dinai Hospital of Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 04/05/1920 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X**M 2□ F Yrs. 219-05-5909 Maryland Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28e-f show other traumatic event, the Medical Examinar must be notified at 1XYes 2 □ No Directo N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 2923 Forest Glen Road United Stated Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after n and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Be Completed by Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Officer Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be Ida Kinsey Lawrence Hooper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2923 Forest Glen Road Baltimore, Maryland 21216 Terrence Hooper - Son item 27 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Veterans Cemetery 09/15/2005 Baltimore, Maryland

22. Name and Address of Facility
Dayid J. Weber Funeral Homes P.A.
5311 Formondson Avenue Baltimore, Maryland 21229 21. Signature of Funeral Service Licensee we Javen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Myocardial Infarction 2 days Acute disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Pulmonary 7 £ Jema days if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner anding physician and use as the burial-transit Renal Failure 2 days resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Mellitus peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Hypertension autopsy performed 2 No this certificate 1 ☐ Yes 2 No 1 Tyes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 7 within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 1 ☑Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide To the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier : Sam Yosolevite, MD RES-000 September 9,2005 o completed cause of death (Item 23a) (Type, Print) Sinai Hospital of Baltimore MD Yaselevitz, Sam 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Blown H. Sporte Registrar 1 4 2005

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State of Maryland / Department of Health and Mental Hygiene For Stete Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 7:45 P Keith Lloyd Henry September 11, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Howard Ellicott City Ellicott City Health & Rehabilitation If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2□F Days Months Director 67 593-34-4751 June 12, 1938 Jamaica. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show the Medical Exeminer near be notified at 1 ☐ Yes 2 No Director Ellicott City Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21043 U.S.A Completed by Funeral 4655 Yorkshire Dr. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 Divorced 'natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Law Enforcement Elementary/Secondary (0-12) College (1-4or 5+) Police Officer . Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: If itam 27 Is markad other t jury or other traumatic evant, III 5 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **Ethel Thomas** David Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4655 Yorkshire Dr. Ellicott City, Maryland 21043 Daughter Grace Henry 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any injury or once. Clarksville, MD 09/17/2005 * 4 ☐ Donation 5 ☐ Other (Specify) Linthicum Chapel Cemetery 22. Name and Address of Facility Slack Funeral Home, P.A 23a. Part Neiter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): physician is the burial Division of Vital Records, P.O. Box 68760. Physician/Medical as anding p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 2 Fetal death 3 Ectopic pregnancy Year Month Day 5 Other (specify) 4☐Pregnant at time of death signed by the a 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 2 No 2 To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this After th 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending To the needs after death, within 24 hours after death.

To tha Funeral Director: A' investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30641 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Rames h Sabapathic 201-109 back Rever Neck Road ballnum Maylan 21221 Sabapathe 201-109 32. Begistrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 4 2005 Registrar

			State	epartment of Health and M Certificate of Death		711115 29827	8
			Registrar 1. Decedent's Name (First, Middle, Last)	Johnnoule of Beauti	Reg. 2. Date of Death	3. Time of Death	_
	Physicia		Vandaly Johnson			10 2005 5:00 PM	vI
1	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Milford Manor Nursing Home	Baltimore		Baltimor e County	
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 ØF 7. Age (In yrs.)ast birth	nday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye DEC 2)	9. Birthplace (State or Foreign Country), NORTH CAROLIM	,
	and	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limit	s
	Maryl f aho	٥	MADILLAND 11/A	BAITIMO	DE CI	12 Yes 2 N	0
	r 28e	Director	10e. Styleet and Number	10f. Zip Code	10g.	Citizen of What Country?	
	h with	a D	4026 ANNELLEN ROX	D 2121	5	USA,	
	ems er.	Iner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.	
36	s afte	by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: BI MI	
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Menthal Hygiene. I the 27 is marked other than "natural; or tems 23a or 28e-f ahow other traumatic event, it a Medical Examinar must be neithed.	edt	15. Decedent's Education 16a.	Decedent's Usual Occupation	16b	b. Kind of Business/Industry	_
215	within 72 ene. than "na re Med	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of work) life. DO NOT use retired)	ing		
CA	filed with Hygiene. other that	Sou	12 THGRADE	JUS DRIVER	2 B	ALTO. CITY SCHOOL SYSTA	Em
Maryland	be fill tal H d oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid	den Surname) /	
7	should be nd Mental marked o	၉	19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street and Number or Rura	Number Gi	ty or Town State Zin Code)	7
<u>N</u>	and 2 sho lealth and m 27 is mu	П	BARBARA BROWN (NIECE) 4	15/ ANNEWED K	1. BAN	THORE MD 2121:	5
ē,	s 1 and if Health item 27 other tr	ı	compton	Disposition (Name of Crematory or other place)	Date 20c	Location - City or Town, State	_
Baltimore	0 = 5		1.△Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify)	LAWN CEME 9-10	6-05 W	bODLAWN MD	. 1
alti	permit. Pag Department Important: any injury o	Ì	21. Signature of Funeral Service Licensee	22. Name and Address of Facility	BROWN	JR. F-UNERAL HOI	NE
<u> </u>	89 5 8 9		Letich N. Williams	2175 D. FULTO	NAVE. E	BALTO, MD. 2121	7
			23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac o	or respiratory arrest,	Approximate Interval Between Qnsey and Death	
) 1	Prrysician /Medical		Immediate Cause (Final disease or condition resulting in death)	1915		Millows)
1	Examiner		Due to (or as a consequence of				1
		ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of	i):			
	icate be executed physician and s the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause, Disease in highly that initiated events c.				
90,	ate be execul hysician and the burial-trar	Ex	resulting in death) Last Due to (or as a consequence of	f):			
8760,	cate b	dical	d				-
9 X	ding l	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
Вох	that the death certific ed by the attending p detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No ☐ Head at the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year	
O.	y th	hys	9 ☐ Unknown				
s, P	S	by P	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		co use contribute to the cause of death?	
Division of Vital Records,	w require been sig should b	ted	- sing fend	Wistant	1 🗆 Yes	2 No 3 Probably 4 □Unknow	n
ec	~ Q 70	Completed	/ Salveles		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?	0
a F	icien: The law certificate has rector, page 2 !		I V D		1☐ Yes 2☑		_
Z.	sicier certif irecto	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	Other	(Check only one)	C C Other (Cornita)	
o	g Phy er this	n; To	27. Manuar of Death 28a. Date of Injury 28b. Ti	me of 28c. Injury at	28d. Describe how in	e 6 □Other (Specify) njury occurred	-
ion	nding ath. r: Afte e fun	Certification:	1 Natural 5 ☐ Pending (Month, Day Year) In 2 ☐ Accident investigation	work? M 1 Tyes 2 No			
ivis	r Atte	tifle	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specily)	m, street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, late)	
	ital o rrs aft ral Di	Ce					_
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, (Check only one) 2 Medical Extminer: On the basis of examination and and manner stated.				
	o the	Med	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)	
	->-0			1)27566	7	9/12/0)	
1	77		30. Name and address of gerson who peripleted cause of geath (leg/23a) (1	Type, Print) 1838 (Th	cene Tre	9/12/0) re Rl 2/208	
	1	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature		· · · · · · · · · · · · · · · · · · ·		-

			State of Maryland / Department of Health and Mental Hygiene 1 - State Registrer Certificate of Death Reg. No. 2 1 5	29829
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last) MYRTLE M. JOHNSON 4a. Fecility Name (If not institution, give street and number) 2. Date of Death Month Day Yeer SFPT 09 2005 4b. City, Town, or Location of Death 4c. County of Death	3. Time of Death
	Funeral Director			ORE Oplace (State or Foreign Unitry) RYLAND
	Maryland B-f show ilied st	tor	10a. State 10b. County 10c. City, Town or Location BALTIMORE CITY	10d. Inside City Limits 1 Yes 2 □ No
	th with the 23a or 28 ist be not	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Coulomb 1207 MOSHER STREET 21217 USA	untry?
036	within 72 hours after death with the Maryland one. than "naturel", or Items 23s or 28s-f show the Modical Examinet must be notified at	by	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amer Black, White Specify: Specify: E	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 TH 1 6 YEARS 1 6 Secondary (0-12) 1 2 TH 1 6 TEARS 1 7 TEARS 1 7 TEAR	•
Maryland	should be filed nd Mental Hygi marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) HENRY B. JOHNSON DETTER S. PLEASANT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zi	
	1 and 2 sl Health and 8m 27 Is r ther treur		MARTINA J. MCARTHUR / NIECE 4316 TRAVANCORE CT, RANDALLSTOW	NN, MD
Baltimore,	Pages I ment of H ent: If ite ury or ot		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1 Competery, crematory or other place) 1 Competery, crematory or other place) 1 Competery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or T 20c. Location - City or T 20c. Location - City or T 20c. Location - City or T 20c. Location - City or T 20c. Location - City or T 20c. Location - City or T 20c. Location - City or T 20c. Location - City or T 20c. Location - City or T 20c. Location - City or T 20c. Location - City or T 20c. Location - City or T 20c. Location - City or T 20c. Location - City or T 20c. Location - City or T	
Ball	permit Depart Import any in		21. Signature and Address of Facility HOWELL FUNERAL HOMELL FUNERAL FUNERAL HOMELL FUNERAL F	
8760, <	The law requires that the death certificate be executed www. www. The law requires that the death certificate be executed www.	dicai Examiner	23a. Part Emer the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shopk, or high family file condition on eause on each line. Immediate Cs se (Final disease or Indition resultin in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of):	Approximate Interval Between onset and Death
O. Box 6	es that the death certifice igned by the attending ph be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	very Day Year
ds, P.	uires that signed by Id be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the underlying cause given in Part I.	
Vital Records,	sicien: The law requir s certificate has been si lirector, page 2 should	e Completed	autopsy prior to co death? 1 Yes 2 No 1 Yes	opsy findings available ompletion of cause of
Division of Vil	ding Phy I. After this funeral o	To B	26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28. Place of Death (Check only one) Cher: Nursing Home 5 Residence 6 Other (Special Noise) 28. Place of Death (Check only one) 28. Place of Death (Check only one) 28. Place of Death (Check only one) Cher: Nursing Home 5 Residence 6 Other (Special Noise) 28. Place of Death (Check only one) 1 Nursing Home 5 Residence 6 Other (Special Noise) 28. Place of Death (Check only one)	fy)
Divis	al or Attences after death	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rura City or Town, State)	al Route Number,
	To the Hospital or within 24 hours after To the Funerel Dir completely filled in	edical (29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as s (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as s (Check only one)	itated, o the cause(s)
)	To the within 2 To the complet	Σ	29b. Signature and title of certifier B Community 29c. License number 29d. Date signed (Month, Q Q Q Q	Day, Year)
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 67 (7 Pouls Geografia)	10 2 15
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 4 2005 32. Registrar's Signature	

DHMH 17 Rev 1/2001

Amend item#1, per DR, G847, 9/16/05 IT State of Maryland / Department of Health and Mental Hygiene 2005

		For Stata Registrar	State of Maryland /	Cei	tificate of D	eaith and iv	Ra	g. No. 2005	29830
ysiciar	n	1. Decedent's Name First, Middle Las	rson Jones				Date of Death Month	Day Year	3. Time of Death
Medica	i .	LEO-JEFFERSON JOHN	B				SEPT.	7, 2005	1:35 A ^M
amine	r	4a. Facility Name (If not institution, give			4b. City, Town, or I			4c. County of Dea	th
		GILCREST NURSING			BALTIMORI				
eral		5. Social Security Number 6. Se	7. Age (In yrs. last t		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bir	hplace (State or Foreign
ctor:	-	243-46-8006 Usual Residence of Decedent	71	Yrs.			July 30,	1934 Nor	th Carolina
44		10a. State 10b. County	10c. City, To	wn or Lo	cation				10d. Inside City Limits
7	0	1470	,,						1 Ty Yes 2 □ No
all o	Director	MD 10e, Street and Number			BALTIMORI 10f. Zip Code	₹			
3 E	2						10	g. Citizen of What Co	ountry?
E C	era	5524 CEDONIA AVE.	12. Was Decedent Ever in U.S.	12 1	21206			U.S.A.	
	by runeral	1 Never Married 2 Married 3X Widowed 4 Divorced	Amed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates:		Vas Decedent of His Yes, specify Cuban Yes 2 No	panic Origin? (Sp., Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	e, etc.
H 70	9	15. Decedent's Edu	ication 16	a. Deced	ent's Usual Occupat	ion	1	6b. Kind of Business/	LACK
to de	Сотріете	(Specify only highest grad	le completed)	(Give	kind of work done du OO NOT use retired)	iring most of work	ing	ob. Kind of Business/	industry
1 8	E	Elementary/Secondary (0-12)	College (1-4or 5+)	engir				STATE OF I	ΜΔΡΥΤ.ΔΝΠ
event.		17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, M.		HILLIMIND
		ROGER JONES				EULA STIE		,	
T T		19a. Informant's Name/Relationship (T)	(pe, Print) 19	b. Mailin				City or Town, State, 2	in Codol
other traumatic	1	GAIL A. JONES/WIF			CEDONIA AV				ap Code)
e de		20a. Method of Disposition	20b. Place		sition (Name of latory or other place)			0c. Location - City or	Town State
- 1		1 Burial 2 Cremation 3 ☐F 4 Donation 5 ☐ Other (Specify)	ISINOVALIDIN STATE			!		,	
בַּ בַּ	ŀ	21. Signal re of Funeral Service Licens			Cemetery Name and Address	9-10-	·2005 I	andsdowne	, MD
eny Injury o		Backen C		Wi 12	lliam C. 206 W. Nor	Brown Co	Baltimor	Funeral Ho	ome P.A.
4.		23a. Fart1. Enter the disease, or comp shock, or heart failure. List only o	ne cause on each line.	not ente	r the mode of dying,	such as cardiac o	r respiratory arres	st,	Approximate Interval Between
ian	-	mmediate Cause (Final disease or condition	ama	est	-ine H	eart	Jail	ceri	Onset and Death
cal		resulting in death)	Due to (or as a consequence						1
ner		Sequentially liet conditions.						Ì	U
	D	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	of):					
the burial-transit	5	mai minateu events	s						
		resulting in death) Last	Due to (or as a consequence	of):					
edicai	2		d						
ed la	2	IF FEMALE:							
Jan/N		23b. Was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat	h 3∏	Ectopic pregnancy			23d. Date of deli	very
Sici	2	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at time of death 9☐ Unknown		Other (specify)			Month	Day Year
Physician/M		9 Unknown							
leted by Physic		Part II. Other significant conditions con	ntributing to death but not resulting	in the un	derlying cause given	in Part I.	23e. Did toba	cco use contribute to	the cause of death?
be	3 -	yautes 1	nexuus,	1	enal		1 ☐ Yes	2. No 3 □ Pro	babiy 4 🗆 Unknown
Completed	2	Jailure,	Arostale	0	moon		24a. Was an	24b. Were aut	opsy findings available
E	5						autopsy performe	death?	ompletion of cause of
		25. Was case referred to medical	-74°					No 1□Yes	2 No
Be		examiner?	lospital:		7 04-	6. Place of Death	77 - 120 - 1	~	11-
2		27. Manner of Death	1 Inpatient 2 ER/O	utpatient Time of	3 DOW	4 Nursing Hon		ce 6 Other (Special	ty) 705/102
Medical Certification: To Be C		1 Natural 5 ☐ Pending		Injury	28c. Injury a Work? M 1 ☐ Ye	s 2 DNo	8d. Describe how	injury occurred	,
Certification:		3 Suicide 6 Could not be	28e. Place of Injury - At home, fa	arm etec			Of Logation (O)	at and More C	
Ē		4 Homicide determined	building, etc. (Specify)	arm, stre	et, factory, office	2	City or Town, S	et and Number or Rui State)	al Route Number,
ai Ce		29a. Certifier 1/8 Certifying Phys	sician: To the best of my knowledg	e, death	Occurred at the time	date and place a	nd due to the com	sals) and manage ==	tated
Medical		one)	ner: On the basis of examination are and manner stated.	nd/or inve	istigation, in my opin	ion, death occurre	d at the time, date	and place, and due	o the cause(s)
2	2	29b. Signature and title of certifier	10		29c. License n		29d	. Date signed (Month,	Day, Year)
		11 Holh	of thely in	ð	1)2	5 205	51	Eplein:	ber 7, 2003
	3	30. Name and address of person who co		(Туре, Р	rint)	11. 0	()	0.1	ber 7, 2003 1d 2120/2
		Wild R.l.	ey Come	62	701 /Y-	Maries	Jr 12	outs.a	14 515 M
State	3	31. Date filed (Month, Day, Year)	32. R cistrar's Signature					3 1000000000000000000000000000000000000	
			100						

JONES

			For			Marylan	d / De	partme	nt of Healt	h and N			200	E 2000
			- State Registra/MEND			ANA B	0.684	<u>ortifica</u>	tg of Dea	th	2. Date of Dea	Reg. No.	200	
I	Physicia	an	Decedent's Name (Firs								Month August	Day	2005	3. Time of Death 9:00 PM M
	/Medic Examin	_	James V 4a. Facility Name (If not in	-		er)		4b. Cit	, Town, or Locati	ion of Death		_	County of Dea	
	CAMIIII	CI.		-	Hyattsv			Н	yattsvil	le.		Pr	ince G	eorge's
	Funeral		5. Social Security Number		Sex 7.	Age (In yrs.		Months	er 1 Year If Un Days Hou	nder 24 Hrs. Irs Min.	8. Date of Birt (Month, Da	h y, Year)	9. Bir	thplace (State or Foreign puntry)
	Director		561-16-9375 Usual Residence of Dece			91	Yrs				Jan 7,	191	4	unk
	yland Iow			County		10c. Cit	y, Town or	Location						10d. Inside City Limits
	a-f sh	ctor	DC Wa	shingt	so n	Was	shing	ton						1 ☐ Yes 2∑ No
	or 28	Director	10e. Street and Number						ip Code		The second second		zen of What Co	ountry?
	death with the Maryland ms 23a or 28a-f show r must be routtled at	erai	1114 McColl	ough C	t. #302	ant Ever in III	e 1		0001	Origin2 (Sr	poity Van or No	USA	14. Race - Ame	arican Indian
·0	fter de ritem irrer	Funerai	11. Marital Status 1 Never Married 2	. Married	Armed Forc	es?	.3.		edent of Hispanic ecify Cuban, Mex		Rican, etc.)		Black, Whit	te, etc.
93	ral', o	þ	3 ☐ Widowed 4 ☐ □	Divorced	If Yes, Give Year or Date	es:		1 🗌 Yes	2⊠ No Spe	cify:			Specify: bla	ick
2-0	72 h	Completed	15. E (Specify on	ecedent's Edy highest gra	ducation ade completed)		/G	ive kind of v	ual Occupation work done during t	most of work	king		nd of Business	
121	within ene. than be M	dmo	Elementary/Secondary		College (1-4 unk	lor 5+)	HI	e. DO NOT	use retired)			mi	litary	
0	illed Hygi other	Be Co	17. Father's Name (First,	Middle, Last)				18. M	lother's Nam	e (First, Middle,			
Maryland 21215-0036	uld be Wenta rrked rrfc ev	To B												
/au	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked othar than "natural; or items 23a or 28a-f show any injury or other traumatic evant, the Modell Examination at any injury or other traumatic evant, the Modell Examination at an and once.	8 3	19a. Informant's Name/R						ss (Street and Nu					Zip Code)
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Baltimore,	ages int of l t: If its y or o		1 ☐ Burial 2 ☐ Cre 1 ☐ Donation 5 🖾	mation 3	Removal from St	ate	emetery, o	crematory or	other place)	1			out, o.,	,
altin	artme ortan injury		21. Signature of Funeral ROng			/		22. Name	and Address of Fa	acility	1 (55 ***	70 1		2
ä	Departing Department of the particular of the pa		Kona	1///	Wade,	yor			Anatomy nore, MD			ват	timore	Street
			23a. Part1. Enter the dis shook, or heart failu	ease, or com ire. List only	plications that car one cause on each	sed the deat th line.	h. Do not	enter the mo	ode of dying, such	n as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician		tmmediate Cause (Final disease or condition resulting in death)		a	C	BRI	NOR	ESPIR	ATO	RY R	FRR	EST	Oliset and Death
	/Medical Examiner	ß.	resoluig ar death)	(Due to (o	as a conseq	uence of):	15051	VE 14	12 An	TEA	11 131	o iĉ	
		er	Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury	ns, ate	b. Due to (or	as a conseq	uence of):	(62)	10 17	CAK	1 7 7 1	100	IK C	
	outed ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	1	c		1441	PERT	TENSIC	No				
760,	te be executed ysicien and te burial-transit		resulting in death) Last	- 1	Due to (or	as a conseq	uence of):							
6876	cate b	Completed by Physician/Medical		•	d									
9 X	death certificate e attending phys d for use as the	/Me	IF FEMALE: 23b. Was decedent preg		23c. If yes, outco	ome of pregna	ancy					2	3d. Date of de	livery
Box	death e atter d for t	ciar	in the past 12 month		4 Pregna	h 2□Feta nt at time of d		3 Ectopic 5 Other (Month	Day Year
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	The law requires that the death certificate the bas been signed by the attending phy bage 2 should be detached for use as the	by F	Part II. Other significant		contributing to dea					art I.				the cause of death?
oro	requi	eted		CIC	J101C 1.	201-1		-1710	ORC		-	/es 2[
3ec	e las has	mpl									24a. Was autop		24b. Were at prior to death?	utopsy findings available completion of cause of
tal			25. Was case referred to	medical					26 P	lace of Dear	1 ☐ Yes	2 No		2 □ No
Z	Physician: r this certific ral director,	To Be	examiner?	111001001	Hospital: 1 In	patient 2	ER/Outpa	tient 3 🗍 🛭	Other	12.1	ome 5 Resid		☐Other (Spe	city)
0 0	ng Ph Iter th neral		27. Manner of Death	Pending	28a. Date of (Month)	Injury Day Year)	28b. Tim		28c. Injury at Work?		28d. Describe h			_
Sio	Attending r death. ector: After by the fune	cati	2 Accident	investigatio	10			М	1 ☐ Yes 2	2 🗆 No	004 1			
Division of Vital Records,	l or At atter d Direct	Certification:	4 Homicide	determined	289. Place C	f Injury - At h g, etc. <i>(Specii</i>	ome, tarm, y)	street, facto	ory, office		City or Tox	otreet and vn, State)	d Number or R	ural Route Number,
_	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.				hysician: To the b									
	he Ho in 24 I he Fu pletel	Medical	(Check only 2 🗌 I	Medical Exa	miner: On the bas and manne	is of examina or stated.	ition and/o	rinvestigatio	on, in my opinion,	death occur	red at the time,	date and	place, and due	e to the cause(s)
	To the within 2. To the I complet	Σ	29b. Signature and title of	-//				2	9c. License numb		1		signed (Mont	
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		1	30. Name and address of						こにならない	10 Y W	ח ואעה	775	111.112	mn 20181
	Sta	ite	31. Date filed (Month, Da	ay, Year)	32. Re	gistrar's Signa	ature	A L	L 147130	FIR	J. 19/60	, r-1 t-1	ر حدد ب	m1) 20131
	Regist		SF	P14	2005	gistrar's Signa	15	Spend	A. Commercial Commerci					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registramend item #19a PER FH C847 9714/05 H 2. Date of Death 0 0.5 1. Decedent's Name (First, Middle, Last) Day 9,2005 **Physician** September Johnson Arthur /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Baltimore Randallstown enter Northwest hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 53 Yrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 52 2cm Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event. The Medical Event. In or many page. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Hes 2 No Director MD Altimores 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4.54. 21163 GRandit Rd 08/3 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify. Specify: Completed by 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hume Products 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sudie MAZ Jul1 HRHAUR J JUHNSON 2 19a. informant's Name/Relationship (Type, Print) Benda Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) woodstock MD 2813 GRand of Le 21163 . 54 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State Don finance 4 □ Donation 5 □ Other (Specify) Valley Money 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BEHS Fureral Tatucia BOHMENS MO 21213 N. CARBline St Buto 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiovascular Disease Athero scleratic **Physician** /Medical Due to (or as a consequence of): Examiner DW Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit the attending physician and resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical should be detached for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has 2 **1** No 1 ☐ Yes 2 ☐ No certificate I 1 ☐ Yes Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Ø No 2√ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b Time of 28c. Injury at Work? Certification: After or Attending 5 Pending investigation 1: Natural 1 ☐ Yes 2 ☐ No nours after death.

nerel Director: Af 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after within 24 hours a To the Funerel D To the Hospitel 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ္ September 9,2005 D0058141 che 10. Name and address of person who completed cause of death (Item 23a) (Type, Print) Randallstown, MD 21133 Read

Registrar

DHMH 17 Rev 1/2001

State

140C

Old

SEP 1 4 2005

31. Date filed (Month, Day, Year)

Box 68760,

Division of Vital Records, P.O.

32. Registrar's Signature

Court

			1 - For State Registrar	State of	Maryland		artment of I rtificate of			Mental Hy		200)5	2983
	Physic	ian	1. Decedent's Name (First, Midd						•	2. Date of D Month	eath Dav	Ye	21	3. Time of Death
	/Medi Examir	cal	Dorothy Louis 4a. Facility Name (If not institution		<u> </u>		4b. City, Town, o	or Location	of Death			9,200 County of D		7:00PM ^M
1			Gilchrist Cer				Towsor					Balti		Э
	Funeral Director		5. Social Security Number 217-26-7925 Usual Residence of Decedent	6. Sex 7	. Age (In yrs. las	Yrs.	If Under 1 Year Months Days		Min.	8. Date of B (Month, P July 1	8,192	9. 24 W	Birthpla Countr est	ce (State or Foreign Virginia
	ryland how		10a. State 10b. County	,	10c. City,	Town or Lo	cation				· · · · · · · · · · · · · · · · · · ·		100	d. Inside City Limits
	Ba-1 s	ector		timore	G]	len A								1 Yes 2 No
	3a or 3	Dir	10e. Street and Number 12704 Kanes	Road			10f. Zip Code	21057			-	zen of What	Countr	y?
980	72 hours after death with the Maryland natural', or Items 23a or 28e-1 show dical Examilian	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Mar 3 □ Widowed 4 □ Divorceo	ned 1 Yes 2	! [XNo		Was Decedent of Information of Yes, specify Cub			ecify Yes or N Rican, etc.)	0- 1	4. Race - A Black, W Specify:		c.
2-0	72 hours "natural", older Exe	eted	15. Deceder (Specify only highe	nt's Education est grade completed)		(Give	lent's Usual Occup	durina mos	st of work	ina	16b. Kir	nd of Busine	ss/Indu	stry
21215-0036	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4	lor 5+)	life. L	Nursing S	d)		•	Cc	ollege	Mai	nor
land 2	illec I Hyg othe	To Be C	17. Father's Name (First, Middle, Oscar Mostel)	,			<u> </u>	18. Moth		e (First, Middle	e, Maiden S			
, Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: if Item 27 is marked any injury or other traumatic ex		19a. Informant's Name/Relations Sandy Mangione,	4			g Address (Street Browntow							ode)
Baltimore,	ges 1 and the street or other		20a. Method of Disposition 1 Websites 2 Cremation	3 □Removal from St	20b. Place	e of Dispo	sition <i>(Name of</i> Patowa ptileer) Brethrei	ce)		Date		cation - City		
ıltim	nit. Pa artmen ortant: injury		4 ☐Donation 5 ☐ Other (S 21. Signature of Funeral Service				Brethrei Name and Addre			2/05 200ard	Gler	Arm,	Man	ryland
å	Dermi Depa Impo sny ii		toest (They Colo			5305 Har	ford I	Road	Baltim	ore,	Maryl	and	21214
г			23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that cau tonly one cause on eac	used the death. th line.	Do not ente	er the mode of dying	ng, such as	cardiac	or respiratory a	arrest,		ir	pproximate nterval Between onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Conc	as a consequer	Hear	+ tailer	~c					Y	GIS
5_	Examiner		Sequentially list conditions,	b										
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	Des to (or	as a sunsequer	ics of).								
o,	execu an and rial-tra	Exa	that initiated events resulting in death) Last	c Due to (or	as a consequer	nce of):								
68760,	cate be executed physician and the burial-transit	dical		d										
P.O. Box 6	death certiff e attending ad for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown		h 2 Fetal de it at time of deat	eath 3	Ectopic pregnancy Other (specify)				23	3d. Date of o	delivery Da	ay Year
	sign Sign J be		Part II. Other significant condition	ons contributing to deal	th but not resultin	ng in the un	derlying cause giv	en in Part I			tobacco us		to the	cause of death?
Division of Vital Records,	The ate h	Completed				<u>s</u> .				24a. Was auto perfo		24b. Were prior t death	o comp	r findings available letion of cause of
Vita	Physician: r this certific ral director.	Be	25. Was case referred to medica examiner?	Hospital:			2□ DOA Oth	051		Check only	one)			7
on of	Attending Physic death. cotor: After this by the funeral d	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendir 2 Accident investig	28a. Date of (Month,		Outpatient Ib. Time of Injury	28c. Injur Wor	4 ∐ Nu vat		me 5 Resi 28d. Describe			oecify (respice
Divisi	al or Attend s after death il Director: , id in by the f	Certification:	3 Suicide 6 Could determ	not be 28e. Place of	Injury - At home , etc. <i>(Specify)</i>	, farm, stre	et, factory, office		- +	28f. Location (City or To	Street and wn, State)	Number or	Rural R	oute Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	29a. Certifier 12 Certifyir (Check only one) 2 Medical	ng Physician: To the be Examiner: On the basi and manner	s of examination	dge, death and/or inv	occurred at the tin estigation, in my o	ne, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) a date and p	nd manner place, and d	as state	d. e cause(s)
	To t To tl	ž	29b. Signature and title of certifie	2/1.			29c. Licens				_	signed (Mo		
, l	12		30. Name and address of person		r Ø	20) /T == 5		6119				, 10,		58
1	1-0		Jason B/a	ck 660	I Nor	An Ch	arles St	- 7	owso	w 02 h	1 21	204		
	Sta Registr		31. Date filed (Month, Day, Year)	4 2005 32. Rev	strar's Signature	K A	print)							

			Tor State Registrar	State of M	aryland / Depa <i>Cei</i>	artment of trificate of	Health an <i>Death</i>	d Mental Hy	gienez 0 (15 29834
Eq.	Physici /Medic		Decedent's Name (First, Middle, Las CHARLES F		KUMP			2. Date of De Septemb	er ⁰ 8, 200	3. Time of Death 5:10P M
	Examir		4a. Facility Name (If not institution, give University of Md Med ()	4b. City, Town, Baltin	or Location of D	eath	4c. County of	Death N/A
\$ \$	Funeral Director			х Дм 2□F 7. Ас 7. Та	ge (In yrs. last birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Bir Min. May 25	1932	B. Birthplace (State or Foreign Country) Maryland
	e Maryland 3a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimor	`e	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2√√No
	th with th	Funeral Director	405 Stevenson Lane	2			204		10g. Citizen of Wh	A
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	Ď	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 24 If Yes, Give Year or Dates:	No	Was Decedent of f Yes, specify Cu		? (Specify Yes or No uerto Rican, etc.)	Specify:	American Indian, White, etc. White
21215-0036	d within 72 h giene. ir than "natu	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	cation de completed) College (1-4or	(Give	dent's Usual Occi kind of work don DO NOT use retir ECTRICIA	e during most of ed)	working	16b. Kind of Busi	,
	should be filed ind Mental Hygis marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) Charles Franklin	Cump				_{Name (First, Middle} e Catherii		
Maryland	and 2 shou saith and M n 27 is mar		19a. Informant's Name/Relationship (7 Roberta M Kump	урө, Print) Wii				or Rural Route Numb		
Baltimore,	permit. Pages 1 and: Department of Health Important: If Item 27 any injury or other tr ance.		20a. Method of Disposition 1 □ Burial 2 1 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		20b. Place of Dispo cemetery, crea	natory or other pl		Date 12/05		ity or Town, State e, Maryland
Baltir	permit. Pag Department important: i any injury o		21. Signature of Funeral Sarrice (Cen				ress of Facility	Mitchell-Wie	defeld Fune	eral Home Inc. Tryland 21212
4	cate be executed whysicien and whysicien and whysicien and the burial-transit	dical Examiner	23a. Part 1. Enter the disease, or companies shock, or heart failure. List only of the control o	a. Intracer Due to (or a:	rebral Hemon s a consequence of):		ing, such as car	ulac of respiratory a	ii 631,	Approximate Interval Between Onset and Death
.O. Box 68	that the death certificate be ex- led by the ettending physicien a detached for use as the burial	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	□Ectopic pregnan □ Other (specify)	су		23d. Date Mont	·
<u>α</u>	86 20		Part II. Other significant conditions of	ontributing to death	but not resulting in the u	nderlying cause o	jiven in Part I.	-		oute to the cause of death?
Il Records,	The law rate has by page 2 sh	Completed						24a. Was auto perfe 1 🗌 Yes	psy pri prmed? de	ere autopsy findings available or to completion of cause of ath?] Yes XX No
Division of Vital	Attending Physician: The death. sctor: After this certificate by the funeral director, pages	Certification: To Be	27. Manner of Death XXNatural 5 ☐ Pending 2 ☐ Accident investigation		jury 28b. Time o lay Year) Injury	f 28c. In	ther: 4 □ Nursi ury at ork? □ Yes 2 □ No		idence 6 Other	d
Divi	5 to 6	Certific	4 Homicide determined	building, e	njury - At home, farm, st etc. <i>(Specify)</i>			City or To	wn, State)	r or Rural Route Number,
	he Hospital in 24 hours a he Funeral C pletely filled i	Medical	29a. Certifier (Check only one) AA Certifying Ph 2 Medical Exam	ysician: To the bes niner: On the basis and manner s	t of my knowledge, deat of examination and/or in stated.	h occurred at the vestigation, in my	time, date and p opinion, death	place, and due to the occurred at the time,	, date and place, ar	nd due to the cause(s)
	To t withi To t	×	29b. Signature and title of certifier			1	15817		_	(Month, Day, Year) mber 8, 2005
Page 1	St Regist	ate	30. Name and address roon who Lewis Chany MD 22 31. Date filed (Month, Day, Year) SFP 1 4	South G		t Baltim	ore, Ma	ryland 212	201	

			1 - For State Registrar	State of I	Maryland / Dep <i>Ce</i>	partment of Health a ertificate of Death	nd Mental Hy	giene 200	5 29835	
	Dhusia	i,	1. Decedent's Name (First, Middle	a, Last)			2. Date of D	eath	3. Time of Death	
	Physic /Medi		Michelle	R	•	LeSane	09	07 200	05 5:00 p M	
	Exami	ner	4a. Facility Name (If not institution		•	4b. City, Town, or Location of	Death	4c. County of Death		
		gerries	1000 Leadenh			Baltimore				
*	Funeral Director		212-58-7188 Usual Residence of Decedent	1 M 2√F	Age (In yrs. last birthda) 53 Yrs.	/) If Under 1 Year If Under 2 Months Days Hours	Min. (Month, D.	7th ay, Year) 30 52	Birthplace (State or Foreign Country) MD	
	yland		10a. State 10b. County		10c. City, Town or I	_ocation			10d. Inside City Limits	
	a-fel	tor	MD NA		Baltim	ore			YYes 2 □ No	
	th the	Director	10e. Street and Number			10f. Zip Code		10g. Citizen of Wha	at Country?	
	afh w 23a	rail	1000 Leadenh	all Stree	t	21230		U.S.	Α.	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show say injury or other traumatic event, the Medical Exam and must be notified at ance.	by Funeral	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Dovorced	12. Was Decede Armed Force led 1 Tes 2,0 If Yes, Give Year or Date:	s?	. Was Decedent of Hispanic Origi If Yes, specify Cuban, Mexican, 1 ☐ Yes 2 ☐ No Specify:	n? (Specify Yes or No Puerto Rican, etc.)	14. Race - / Black, V Specify:	American Indian, White, etc.	
2-0	72 ho	Completed	15. Decedent	's Education		edent's Usual Occupation		16b. Kind of Busine	Black ess/Industry	
2	ifhin 180 .	npie	Elementary/Secondary (0-12)	College (1-4c	lito	e kind of work done during most of DO NOT use retired)	of working		,	
2	ygien ygien t, th	Con	12th grade	na		ord Clerk		Social S	Security Adm	
and	be fill fal H d ott	Be	17. Father's Name (First, Middle, I	•			s Name (First, Middle	, Maiden Sumame)		
2	J Mer J Mer Jarke	1º	William Taylo				e Mabrey			
Maryland	d 2 sł th and 7 le n traun		19a. Informant's Name/Relationsh			ling Address (Street and Number				
ب	1 an Heal em 2		Donte LeSane 20a. Method of Disposition	-Son	20b. Place of Disp	Monavia Road	Date Date		21206	
<u> </u>	ages infol t: If if		U⊒Burial 2 ☐ Cremation	3 □Removal from Stat	te cemetery, cre	ematory or other place)		20c. Location - City		
Baltimore,	arfme arfme ortan injury		4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service L			Memorial Par		5 Arbuti	us, Md	
B B	Per fine eny	5 13	1 Branda	Melloin	4	2. Name and Address of Facility arch F/H West 300 Wabash At	7e, Balti		d 21215	
1	Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)	a. San	018095	iter the mode of dying, such as ca	ardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death	
	Examiner			Due to (or a	as a consequence of):				1	
2		ē	Sequentially list conditions,	b. — Qualto (or a	is a consequence off:					
	ufed d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
o Î	icafe be execufed physician and the burial-fransit		resulting in death) Last	C. Due to (or a	is a consequence of):					
8760	fe be ysicie	dicai		d						
Φ		(D) +								
О. Вох	that the death certificated by the attending prode as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3[at time of death 5[Ectopic pregnancy Other (specify)		23d. Date of Month	delivery Day Year	
<u>n</u>	The law requires thaf ife has been signed b age 2 should be defa	by Pt	Part II. Other significant condition	s contributing to death	but not resulting in the u	Inderlying cause given in Part I.	23e. Did to	bacco use contribute	e to the cause of death?	
Vital Records,	n sign	q p	Pulmory	F6	135-3				Probably 4 □Unknown	
ပ္ပ	s been si	Completed	J		•		24a. Was	an 24h Word	autopsy findings available	
ř	The lay cafe has page 2	E O					autop perfo	rmed2 prior t	to completion of cause of	
_	(D) LL	0	25. Was case referred to medical			26 Place of	1 ☐ Yes Death (Check only o	20 No 1 Y	es 2 No	
>	Physicien: this certific ral director,	To B	examiner?	Hospital: 1 ☐ Inpat	tient 2 ER/Outpatie	Oth	ng Home 9 Resid		inacińu)	
	ng Ph ffer fh neral		27. Manner of Death 1 Natural 5 Pending	28a. Date of In (Month, D	jury 28b. Time o	f 28c. Injury at Work?		ow injury occurred	респу	
20	Attending r death. ector: Affe by the fune	catio	2 ☐ Accident investiga	ation	,2.,	M 1 Yes 2 No				
DIVISION	tel or Att rs affer d al Direct ed in by t	Certification:	3 Suicide 6 Could no 4 Homicide determin	and 28e. Place of Ir	njury - At home, farm, st atc. (Specify)	reet, factory, office	28f. Location (S City or Tow	Street and Number or on, State)	Rural Route Number,	
	To the Hospitel or At within 24 hours after or To the Funeral Directomplefely filled in by	edical	29a. Certifier 1 ertifying (Check only one) 2 Medical E	Physician: To the bes xaminer: On the basis and manner s	or examination and/or in	h occurred at the time, date and p vestigation, in my opinion, death o	place, and due to the occurred at the time, o	cause(s) and manner date and place, and d	as stated. due to the cause(s)	
	To the within 2. To the complet	×	29b. Signature and title of certifier			29c. License number		29d. Date signed (Mo	onth, Day, Year)	
	1		1/1/	2		1146	120	9-9-	- 2005	
6	ı		30. Name and address of person w	ho completed cause of	death (Item 23a) (Type,	Print)				
)	- 76		1 Decear	SX	1 5th 1	Print) Print) Print	Proltin	ore 14	D 21207	
**	Stat Registra		31. Date filed (Month Sep Year)	4 20.05 32.	ar's Signature					

			. For	State of Marylan	d / Department of Hea	alth and Menta	l Hygiene	2005	29836
			1 - State Registrar		Certificate of De	eath	Reg. No.		
	Physici		1. Decedent's Name (First, Middle, La Bertha	Mae Mae	Low	△ Mo	e of Death nth Day	ha Zone	3. Time of Death 名・山かっ м
	/Medio Examir		4a. Facility Name (If not institution, give		4b City, Town, or Lo		4c.	County of Deeth	Dirtop
			Maryland Ge	neral Hox	oital Baltima	re City			
п	Funeral Director		,	5ex 7. Age (In yrs. I			e of Birth onth, Day, Year)	_	ace (State or Foreign ry)
	D		213-10-9081 Usual Residence of Decedent		7	01	24	18 DO	
	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Heath and Mental Hygiene. ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event. The Modical Examinar must be notified at injury or other traumatic event. The Modical Examinar must be notified at £.	ō	10a. State 10b. County MD NA		.Town or Location			10	d. Inside City Limits 1 X Yes 2 □ No
	r 28a-	Director	10e. Street and Number	Da	10f. Zip Code		10g. Citi	zen of What Count	ry?
	th with	al D	4514 Belvieu A	ve	212	15		U.S.A.	
	tems	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Was Decedent of Hispa If Yes, specify Cuban, I	anic Origin? (Specify Ye Mexican, Puerto Rican,	s or No- etc.)	14. Race - America Black, White, e	
336	urs afte	by F	1 ☐ Never Married 2 ☐ Married 3 🌠 Widowed 4 ☐ Divorced	1 ☐ Yes 2 M No If Yes, Give Year or Dates:	1 ☐ Yes 21 No S	Specify:		Specify: Blac	7 k
21215-0036	72 hou		15. Decedent's E (Specify only highest gr		16a. Decedent's Usual Occupatio (Give kind of work done duri- life. DO NOT use retired)	on ina most of working	16b. Ki	nd of Business/Indi	
121	within ne. han "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)					
d 2	filed with Hygiene. other than		12th grade 17. Father's Name (First, Middle, Last	na "	Senior Clei	<u>r K</u> 3. Mother's Name <i>(First,</i>			Service
/lan	Mental Mental arked o	To Be	Paige Durham		Ве	ertha Bec	kham		
Maryland	2 should and Men is marke sumatic		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Address (Street and	Number or Rural Route	Number, City o	r Town, State, Zip (Code)
	1 and Health em 27 Ither tr		James Durham-B 20a. Method of Disposition		4514 Belvieu	Ave, Bal		md 2]	215
Baltimore,	Pages nent of I int: If its iry or o		1 v Gurial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specie	_nemovarmom state	lace of Disposition (Name of emetery, crematory or other place) butus Memoria				
ä	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lice		22. Name and Address of		JALL	outus, N	ia
m	Depa Impo any ir		Monalde	C. Sught	4300 Wabash	h Ave, Bai	ltimore	e, Md 2	21215
			3a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that caused the death one cause on each line.	n. Do not enter the mode of dying, s	such as cardiac or respin	atory arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		mmediate Cause (Final is ase or condition ulting in death)	a0C	psis				Oliset and Death
	Examiner		- 1	Due to (or as a consequ	ence of):	mthy			
		ner	Sequential / list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Die to (or as a consequ	Jerice of).	Milly			
	acuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	. Aspiruti	n Mumor	1ia			
,092	te be executed ysician and ie buriat-transit	calEx	resulting in death) cast	Due to (or as a co sequ	ience of):				
687	e X			d		Book to the state of the state			
Вох	h certi ending use a	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1□Live birth 2□Fetal			2	23d. Date of deliver	y
	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as t	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of de				Month [Day Year
P.0	that the	Phy	Part II. Other significant conditions	contributing to death but not resu	ulting in the underlying cause given i	in Part I. 23	e. Did tobacco u	se contribute to the	cause of death?
Records,	w requires that the di been signed by the should be detached	d by					1 🗀 Yes 2 🛭		
000	aw rec s beer 2 shou	plete				24	a. Was an		sy findings available
		Completed				10	autopsy performed? Yes 2 No	death?	pletion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospitali		6. Place of Death (Chec			
of	Phys ral dii	. To	1 Yes 2 No 27. Manner of Death	And the second second	ER/Outpatient 3 DOA Cther. 28b. Time of 28c. Injury at	4 ☐ Nursing Home 5	Residence 6		
ion	utending Ph death. ctor: After th the funeral	atlor	1 ▼Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury Work?	s 2 □No	,,,,	,	
Division	or Attencatter death Director: in by the	Certification:	3 Suicide 6 Could not to determined		me, farm, street, factory, office		ation (Street and	d Number or Rural	Route Number,
	Hospital or A 24 hours after Funeral Direct etely filled in by								
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	29a. Certifier 1 Certifying P. (Check only one)	miner: On the basis of examinat and manner stated.	wledge, death occurred at the time, ion and/or investigation, in my opinion	date and place, and due on, death occurred at th	to the cause(s) e time, date and	and manner as sta place, and due to t	ted. he cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier		29c. License nu	umber On	29d, Date	e signed (Month, D.	ay, Year)
)	8		M			84551	Sel	Hember	-04 2005
6	2		30. Name and address of person who	completed cause of death (Item	23a) (Type, Print)	Wand BE	Nem	1 Hoon	tal
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signal	ture B. Apolio	JULIU CIL	TILIUI	HUSP	141
	Regist		SEP :	1 4 2005 Means	J. J. J. J. J. J. J. J. J. J. J. J. J. J				

		•	1 - For State Registrar	State of Ma	aryland /				ealth a			Reg. No.	005	2983
9			1. Decedent's Name (First, Middle, L	.ast)							Date of De. Month	ath Day	Year	3. Time of Death
	Physici /Medio		Julia	A			Le	edbe	tter		September	11	2005	8:16 pm
	Examir	1.0	4a. Facility Name (If not institution, g	ive street and number)			4b. City,	Town, or	Location	of Death		4c. Cou	unty of Death	
		drei 💂	Sinai Hos	spital			Ü		mor					
Ę.	Funeral			Sex 7. Ag	e (In yrs. last		If Under Months	1 Year Days	If Under Hours	Min.	Date of Bird (Month, Da	y, Year)	Cour	
-12	Director		212-46-4009	1□ M 2 X F	58	Yrs.				(03 12	2 47		MD
	P		Usual Residence of Decedent		10c. City, To	own or Lor	cation						1	10d. Inside City Limits
	how	<u>.</u>	10a. State 10b. County											1X Yes 2 □ No
	Ba-f	ct	MD NA		ват	timo						10- 00	-4 MIN -4 Com	-1-0
	ith th	Oire	10e. Street and Number				10f. Zip					•	of What Coul	
	72 hours after death with the Maryland natural', or items 23a or 28a-f show dical Exact net must be notified at	Funeral Director	3912 West Stra						1215				U.S.A	
	ems erm	Ine	11. Marital Status	12. Was Decedent Armed Forces?		13. V	Vas Dece Yes, spe	dent of Hi cify Cuba	spanic Or n, Mexicai	igin? (Spe n, Puerto F	cify Yes or No lican, etc.)	- 14.	Race - Americ Black, White,	
9	afte or it	F	1 Never Married 2 Married	If Yes, Give	No	1	Yes	2 J No	Specify:			Spi	ecify: D	lack
21215-0036	ours I Ent	d by	3 Widowed 4 Divorced	Year or Dates:								40h Kind		
2-(72 h 'natu	Completed	15. Decedent's (Specify only highest of	Education grade completed)	10	6a. Deced (Give)	lent's Usu kind of wo DO NOT u	rk done o	<i>during</i> mos	t of workin	g	16b. Kind (of Business/In	loustry
2	within ene. then "	шb	Elementary/Secondary (0-12)	College (1-4or	5+)				ovi	aor		Sal	f Emp	loved
2	filed w Hygien sther ti		12th grade	na na		рау	Car	e Pi			(First, Middle,			10/04
밀	d la d	Be	17. Father's Name (First, Middle, La	51)									,	
Sa		은	Rufus Bradley				A 11	(0)		h Br		as City of To	um Stata Zir	Codal
Maryland	C1 40 = 60		19a. Informant's Name/Relationship		_		-	,			Route Numb			
	and lealth m 27		Jesse Ledbette	er JrSo					niia		ane,		ion - City or To	
Se	S E		20a. Method of Disposition typ Burial 2 Cremation 3	□Removal from State	0.0	e of Dispos etery, crem	natory or o	me or other piac	e)	D	ale	ZUC. LOCATI	ion - City or 1	own, State
Ĕ	Pages nent of I ant: If its ury or o		4 Donation 5 Other (Spe		Kinc	n Mei	mori	al I	Park	9/1	6/05	Rand	allst	own, Md
Baltimore,	permit. Page Department of Important: If eny injury of 20028.		21. Signature of Funeral Service Lic	censee		22 M.	Name ar	nd Addres	ss of Facil	št				
m	9 9 1 9		Timette	CK. Ime	2	4.	300	Waba	ash	Ave,	Balt	imore	, Md	21215
et and	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition	omplications that cause thy one cause on each i	ine.	Do not ente	er the mod	1	g, such as		r respiratory a	rrest,		Approximate Interval Between Onset and Death
10	/Medical		resulting in death)	-	a consequen	ce of):	153-1							
	Examiner		Company of the Control of the Control	h Hy	perten	SION								
-	- No.	je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or als		ice of):								
	ate be executed hysician and the burial-transit	Examine	Cause (Disease or injury that initiated events) . D	19 hot c	Ś								
Ć.	exection and and rial-tr		resulting in death) Last	Due to (or as	a consequen	ice of):								
190	e be /sicia e bul	cal		d										
68	tificat ng phy as th													
Вох	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth]Ectopic p	roonanou	,			23d	. Date of deliv	•
m	death a atte	cia	in the past 12 months?	4☐Pregnant a			Other (s						Month	Day Year
P.O.	at the de by the a	Syc	9 Unknown	9□ Unknown										
	E 2 8		Part II. Other significant condition	s contributing to death	but not resultin	ng in the ur	nderlying	cause giv	en in Part	l.	23e. Did	obacco use	contribute to t	the cause of death?
ds	uires t signe Id be	d by									10	Yes 2□N	lo 3∏Pro	bably 4 dnknow
Records,	w requir been si should	Completed									24a. Was	an 2	4b. Were aut	opsy findings availab
ž	has has	E G										ormed?	death?	ompletion of cause of
=											1 Yes	2 No	1 🗌 Yes	2 No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medicat examiner?	Hospital:				Oth	or:		(Check only			
of	S 5	၉	1 Yes 2 No	1 inpat		VOutpatien		UA	4 L N		ne 5 Resi			179)
Ē	ding Phy h. After thi funeral	5	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inj (Month, D	ay Year)	Injury	м	28c. Injur Wor	k?` Yes 2[
Division	Attending r death. sctor: After by the fune	Certification:	2 Accident investiga 3 Suicide 6 Could no	t be		- 4			163 2		of Location	Street and A	lumber or Ru	ral Route Number,
\geq	or At ter d irsct	E	4 Homicide determin	288. Place 01 II	itc. (Specify)	e, rarm, str	reet, racto	гу, опісе			City or To		uniber of his	as rioble riambor,
a	itaic irsaf ral D													
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying (Check only 2 Medical E.	Physician: To the bes xaminer: On the basis and manner s	of examination	edge, deatl n and/or in	h occurred vestigation	at the tirn, in my o	ne, date a pinion, de	nd place, a ath occurr	and due to the ed at the time,	date and pla	ace, and due	siated. to the cause(s)
	o the o the	Me	29b. Signature and title of certifier	/	7		29	c. Licens	e number			29d. Date s	igned (Month	. Day, Year)
	F ≱ F 8			2 1//				04	134-	760		Se	plember	11, 2005
	X		Phodenty 1	me	doub (leam or	3a) (Tunc	Print)	70	JT	CV T	111	-	7	11, 2005
	2		30. Name and address of person w	12401 W.	0 1		1.0	6000	Pi	timor	e MI	200	1215	
	~		Sinai Hospital 31. Date filed (Month, Day, Year)		Be ved trar's Signature		N	0	1021	INTO	1 10			
1	St Regis	tate	CEP 14	2005	es B	25.5								

Tring of

			1- For State of Maryland / Dep	partment of Health and ertificate of Death	d Mental Hyg	iene g. No. 2005	29838	
	Physic		1. Decedent's Name (First, Middle, Last) (COCPON) 200		2. Date of Death Month	h Day Year	3. Time of Death	
	/Medi Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of De	eath JN	4c. County of Death BACTIM		
	Funeral Director		5. Social Security Number 216-01-4914 0. Sex 1 ☑ M 2 ☐ F 92 Yrs. Usual Residence of Decedent) If Under 1 Year If Under 24 H Months Days Hours M		Year) Cou	place (State or Foreign intry) Maryland	
	death with the Maryland ms 23a or 28a-f show	ctor	10a. State 10b. County 10c. City, Town or L MD Baltimore Reis	ocation sterstown		10d. Inside City Lim 1 ☐ Yes 20%		
	3a or 2	I Dire	10e. Street and Number 211 E. Chatsworth Avenue	10f. Zip Code 21136	10	Og. Citizen of What Cou	ntry?	
980	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Heath and Mental Hygiene. If Item 27 is marked other then "natural", or Items 23s or 28s-f show or other treumatic event, the Medical Expransi	by Funeral Director		Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 ☐ Yes 2 ☒ No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race · Ameri Black, White,		
21215-0036	od within 72 h giene. er then "natu , the Medical	Completed	(Specify only highest grade completed) (Give	adent's Usual Occupation a kind of work done during most of v DO NOT use retired) DO1 Bus Contrac	vorking	16b. Kind of Business/Ir Transpo	rtation	
	2 should be filed within and Mental Hygiene. Is marked other then eumatic event, the M.	Be	17. Father's Name (First, Middle, Last) Charles Lockard	18. Mother's N	lame (First, Middle, M cha Gardr	,		
Maryland	2 shoul and Ma Is mart	T ₀	19a. Informant's Name/Relationship (Type, Print)	ing Address (Street and Number or			Code) 21136	
	s 1 and f Health item 27 other to		20a. Method of Disposition 20b. Place of Disp	E Chatsworth Aver		erstown, Ma		
Baltimore,	permit. Pages 1 and 2. Department of Health a Important: If item 27 is any injury or other treu		'4 □ Donation 5 □ Other (Specify) All Sair	nts Cem. 9/ 2. Name and Address of Facility	11824 Reis	sterstown R		
	Frysician		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final		iac or respiratory arres	stown, Mary	Approximate Interval Between Onset and Death	
1	/Medical Examiner		disease or condition resulting in death) a	END ST	AGG			
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) that initiated events					
8760,	cate be executed bhysicien and the burial-transit	dical Exa	resulting in death) Last C. Due to (or as a consequence of):					
O. Box 6	The law requires that the death certific tle has been signed by the attending p tage 2 should be detached for use as	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year	
Records, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the u	ınderlying cause gıven in Part I.		acco use contribute to the		
		Completed			24a. Was an autopsy performe	ed? prior to cor death?	psy findings available mpletion of cause of	
Vital	Phyelclen: The this certificate har all director, page	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatiel	Other	eath (Check only one)) ice 6 □Other (Specify	7)	
Division of	Attending Phyer death. ector: After this by the funeral dis	Certification; T	27. Manner of Death 1 Autural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) (Month, Day Year) 28b. Time of Injury		28d. Describe how		9	
Divis	el or Attences after death	Sertifle	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rura State)	l Route Number,	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) 1 Sertifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place vestigation, in my opinion, death occurred.	ce, and due to the cau curred at the time, date	ise(s) and manner as st e and place, and due to	ated. the cause(s)	
	To To Corr	Σ	29b. Signature and title of certifier	29c. License number	1	d. Date signed (Month, I		
Ì	0		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)		EPTEMBER MD 7 1133	. 10 7005	
	Sta Registr	-	31. Date filed (Month, Day, Year) SEP 1 4 2005	Ander Com	<u> </u>	2115		
	Registr	ar	SEP 1 4 2005 ► Blogues B.	Aportes.				

1 - State Registrar Certificate C	f Health and Mental Hygiene of Death Reg. N2 0 0 5 2 9 8 3 9
1. Decedent's Name (First, Middle, Last) Physician Marsia, Varyion Loovmans	Date of Death Month Day Year
/Medical Marie Navier Looyillalis	SEPTEMBER12, 2005 10:10P M
Saint Joseph Medical Center	Towson Baltimore
Funeral Director 5. Social Security Number 218–54–3674 6. Sex 1 D M 2 D F 91 Yrs. Months Da	
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Maryland Baltimore Baltimore	1 ☐ Yes XXX No
Maryland Baltimore Baltimore Maryland Baltimore B	de 10g. Citizen of What Country? USA
10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10c. City	of Hispanic Origin? (Specify Yes or No- Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Give kind of work do	one during most of working
3 Widowed 4 Divorced If Yes, Give Year or Dates: 1 Yes 3\to \text{10} \\ \text{15. Decedent's Education (Specify only highest grade completed)} \\ 16a. Decedent's Usual Octorior (Give kind of work doffile) in the Do Not use respectively to the property of the Do Not use respectively in the D	Education
N p for the control of the control o	18. Mother's Name (First, Middle, Maiden Surname)
Francis Joseph Looymans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Str. School Str. School	Marie Ann Vitek
Sr. Bernice Feilinger SSND 6401 North Char	reet and Number or Rural Route Number, City or Town, State, Zip Code) les Street Baltimore, Maryland 21212
Products Joseph Looyildits 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Str. Sr. Bernice Feilinger SSND) 19b. Mailing Address (Str. Sr. Bernice Feilinger SSND) 20a. Method of Disposition 20b. Place of Disposition (Name of Commeter) 20b. Place of Disposition (Name of Commeter) 20c. Method of Disposition (Name of Commeter) 21. Signature of Funeral Service Licensee	place)
21. Signature of Funeral Service Licensee 22. Name and Ac	dress of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line.	dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death
Physician Immediate Cause (Final disease or condition resulting in death) RIGHT LOWER LOBE PNEU RIGHT LOWER LOBE PNEU A RIGHT LOWER LOBE PNEU	MONIA HOURS
Examiner	
Sequentially list conditions, if any, leading to immediate cause. Enter Undertrying Cause (Disease or injury	
that initiated events c.	
S P P P P P P P P P P P P P P P P P P P	
d	
	given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 O 3 Probably 4 Unknown
- 0 - ()	24a. Was an autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner? 1	26. Place of Death (Check only Te) Other: A Table in the Telephone of Table in the Telephone of Table in the Telephone of Table in the Telephone of Table in the Telephone of Table in the Telephone of Table in the Telephone
The state of the s	njury at 28d. Describe how injury occurred
To the second of	Work? 1 □ Yes 2 □ No
building, etc. (Specify)	ce 28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier Check only 29 Medical Examinar: On the basis of examination and/or investigation, in a	e time, date and place, and due to the cause(s) and manner as stated. ny opinion, death occurred at the time, date and place, and due to the cause(s)
et et et et et et et et et et et et et e	ense number 29d. Date signed (Month. Day, Year)
Oballo, My D25	886 Sep. 13-2005
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	V
LILIA CEBALLOS M.D. 7601 OSLER DRIVE	TOWSON, MARYLAND 21204

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year Risdon McClendon 6:00 A. M SEPtember 10,2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Purnie Baltimore Washington Medical Center
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Glen If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 X M 2 □ F Director 241-54-6883 69 1 - 24 - 36N. Usual Residence of Decedent Pages 1 and 2 should be Ilied within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Items 23s or 28s-f show the Medical Extending to multipled at Md. **Funeral Director** 1 Yes 2 No Anne Arundel Glen Burnie 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6398 N. Centennial Pl. 21061 USA Ma Clendon, Risdon nore, Maryland 21215-0036 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes Mo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Chef-Supervisor other Hausners Rest 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Is markad 0 Risdon McClendon, Sr. Johnsia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21061 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If itam 27 Is
any injury or othar trau Lena McClendon Daughter 6398 N. Centennial Pl., Glen Burnie, more, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Cedar Hill Cem. 9-16-05 Anne Arundel Co. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 9 ad Wave March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician RNLEPHALOPATHY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CEREBRO VASCULAR ACCIDENT Sequentially list conditions, if any leading n immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner and I-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): sician a burial Box 68760 Physician/Medical the ρh as attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No detached the 9☐ Unknown 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 To Division of Vital Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred Atter Certification: 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Diractor 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Fune completely ti Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. belle SEPTEMBER 10,2001 leasse hun D0055973 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Spring MD 11500 Silver Sutherland hill Worl Deise 32 Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 4 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 29841 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year September 5, Robert J. Miller 2005 5:22 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 1742 Whitfield Ct. Crofton Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1**X** M 2□ F Yrs. Director 579-12-6856 88 6-11-1917 New York Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Exactine must be notified at 1 Yes 2 No Director Maryland Anne Arundel Crofton the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Нетs 23a 1742 Whitfield Ct. 21114 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X7 Yes 2 □ No If Yes, Give Year or Dates W. W. II 1 ☐ Never Married 2 ☐ Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: White 3

Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Salesman Paper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fil. Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic even 2008. Be Charles Thomas Miller Agnes Gertrude McGrath 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) <u> Charles T. Miller/ Nephew</u> 2011 Warners Terrace South, Unit 127, Annapolis, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 9-9-05 Suitland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home this 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ATHEROSCLEROTIC CARDIOVASCULAR DISCHE **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and Due to (or as a consequence of): physician a Box 68760, Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death Year Day 5 Other (specify) Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 Dunknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 ☐ Yes 2 No 1 🗌 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No I Director: d in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direc completely filled in by 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) SEPTEMBER 7, 2005 D31136 of death (Item 23a) (Type, Print) 7 , 9005 KICBAIDE RD., BACTIMORE MID 21236

State Registrar

31. Date filed (Month, Day, Year) SEP 1 4 2005

C-WALCACE

(m) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MEADOWCROFI 5:23 AM LARA 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1+1 gu Are If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Sex 7. Age (In rs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Min 1 M 2 F 219-22-861 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show traumatic evant, the Medical Examiner must be notified at 1 Nes 2 No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4404 "natural", or items 23a 21206 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. white 2 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Importent: If itam 27 is marked other than "na any injury or other traumatic event, If a Made once. Elementary/Secondary (0-12) College (1-4or 5+) 12+4 NA DAYCARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNKnown ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4404 Ms INDA O'TARKE Y RASPE AVE Balte 21206 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) +☐Burial 2 ☐ Cremation 3 ☐ Removal from State (13/05 ` 4 □Donation 5 □ Other (Specify) BALT. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Home CHTD. Puneral TellA HARTZEY Miller 7527 har Ford RO. BALTO 23. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certiticate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical JF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 🗌 No 1 Yes 2 No 1 Yes : After this certifica e funeral director, p Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To tha Funeral Diractor: A completely tilled in by the fu 1 Tes 2 No 2 Accident investigation tilled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Dav. Year) Doo6321 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/200

State

Registrar

Carrela.

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Registrar's Signature

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31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SEPT. **EMMA** 10^{ay} 200^{Year} LEE MARABLE 3:15A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOPKINS ELDER PLUS ASST. EDGEMERE
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. LIVING BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Hours 1□M **3**□F Months Director 224-10-4706 91 05/17/1914 VIRGINIA Usual Residence of Decedent with the Maryland 10a State 10b Counts 10c. City, Town or Location Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director BALTIMORE CITY 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1044 VALLEY STREET Funeral 21202 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural", or iter Black, White, etc. 1 ☐ Never Married 2 ☐ Married þ 1 Yes No 3 XWidowed 4 ☐ Divorced Specify: BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6ТН HOUSEKEEPER DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM HENRY BAILEY FRANCES WADE 19a. Informant's Name/Relationship (Type, Pnick) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If Item 27 Is I ury or other trau MILDRED BAILEY 1044 VALLEY STREET, IN-LAW BALTIMORE, MD 21202 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State LORRAINE PARK CEM 9/16/05 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. WOODLAWN, BALTO CO `4 Donation 5 Dother (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, Enter the disease, or complications that caused the greath. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Vance /Medical Due to (or as a consequence of): Examiner asc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Due to (or as a consequence of) Box 68760, attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 2 No 1 Yes Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 17 557 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 \ Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type init) Bney Eastern gistrar's Signature 2005 Registrar

			For State Registrar	State of Marylar	nd / De <i>C</i>	partment of H <i>ertificate of L</i>	ealth and M D <i>eath</i>		giene200	5 29844
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Day Yea	3. Time of Death
	Physicia /Medic		Agnes V. Murray					Sept	\$ 200	
	Examin Funeral	er	4a. Facility Name (If not institution, give s Belfir Aeal 1 5. Social Security Number 6. Sex	h+ Rehab	Cen'k	Belling If Under 1 Year Months Days	Location of Death If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Nov. 6	v. Year)	Birthplace (State or Foreign Country)
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	yland how		10a. State 10b. County	10c. C	ty, Town or	Location				10d. Inside City Limits
	e Ma	Director	Md. Harford		В	el Air				1 Tyes 2 No
	or 24	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What U.S.A.	Country?
	s 23e	eral	826 Flintlock Dri	.VE 12. Was Decedent Ever in U	IS 1	2101		ecify Yes or No-		merican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23e or 28e-f show important: If item 27 Is marked other than "natural", or items 25e or 28e-f show any injury or other traumatic avant, The Medical Evantal continuation inclined at anone.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	,	3. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	n, Mexican, Puerto Specify:	Rican, etc.)	Black, W Specify:	
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5	filed v Hygie Sthar t		12 years 17. Father's Name (First, Middle, Last)		пош	emaker	18. Mother's Name	e (First, Middle,	Maiden Sumame)	
Maryland	2 should be filed withir and Mental Hygiene. Is markad othar than surmatic avant, the Ma	To Be	Harry Wortman				Ann Murr	ay		
ary.	shoul nd Me mark mark	ř	19a. Informant's Name/Relationship (Ty	рө, Print)		ailing Address (Street a				
	1 and 2 Health a am 27 Is		James Murray/son			Flintlock		el Air,	Md. 21015	
altimore,	es 1 a of He of He fitam		20a. Method of Disposition 13 Burial 2 ☐ Cremation 3 ☐ P	20b.	Place of Di cemetery, o	sposition (Name of crematory or other plac	θ)	Date	20c. Location - City	or Town, State
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Salt	permit. Pag Department Important: I any injury o		21. Signature of Funoral Service License	30		22. Name and Addres	s of Facility Funeral	Home of	Bel Air,	Inc.
8	20 E 2 9		23a. Part1. Enter the disease, or compl		4b D					2 1 0 1 4 Approximate
	Physician /Medical Examiner		shock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conse	ova	scular	Acc	iden	+	Interval Between Onset and Death
	- 13	Je.	Sequentially list conditions, if any, leading to immediate	Due to (or as a nonse	quanea or):	1				
6	ocuted nd ransit	Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	;						
oʻ	e exe ian a urial-1	Ë	resulting in death) Last	Due to (or as a conse	quence of);					
68760,	icate be exec physician and s the burial-tra	edicai		j		· · · · · · · · · · · · · · · · · · ·				
.O. Box	death certit e attending ed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	33c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fel 4 ☐ Pregnant at time of 9 ☐ Unknown	al death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of Month	delivery Day Year
<u>α</u>	law requires that the as been signed by th 2 should be detache	by Pł	Part II. Other significant conditions con	ntributing to death but not re	sulting in th	e underlying cause give	en in Part I.	23e. Did to		e to the cause of death?
Records,	w require: been sig should b	ed b	Coronary	Avery	1)15	ease		10	Yes 2₽No 3□	Probably 4 Unknown
000	aw re s bee 2 sho	Completed	Peripheral	Vascu	ar	Diseas	e	24a. Was		autopsy findings available to completion of cause of
	0 4 9	E O	70,000	0000000	54 (,		perfo	rmed? 👉 death	1? (es 2□46
ita	ician: Th certificate ector, pag	Bec	25. Was case referred to medical examiner?				26. Place of Deal	th (Check only o	one)	
of Vital	ding Physician: n. Atter this certific tuneral director,	2	1 ☐ Yes 2 ₹ No		-	itient 3 DOA Oth	4 Harring Ho		dence 6 Other (S	pecify)
n c		on:	27. Man of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Tim Inju	ry Wor		28d. Describe I	how injury occurred	
Sio	Attending r death. actor: Atterby the tune	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At	home farm		Yes 2 □ No	28f Location (Street and Number or	Rural Route Number,
Division	or At after of Dirac in by	ertif	4 Homicide determined	building, etc. (Spec		, street, factory, office		City or To	wn, State)	, (13/13/10/10/10/10/10/10/10/10/10/10/10/10/10/
]	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely tilled in by the t	Medical Certification:	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my kr ner: On the basis of examin and manner stated.	nowledge, d nation and/o	eath occurred at the tin r investigation, in my o	ne, date and place, pinion, death occur	and due to the rred at the time,	cause(s) and manner date and place, and o	as stated. due to the cause(s)
	To the within To the comp	ž	29b. Signature and title of certifier	1 00		29c. Licens	e number		29d. Date signed (Mo	onth, Day, Year)
			Manne	17/6/	m	DI	9583	-	septem	ber 10,200
	6		30. Name and address of person who comes and address of person who comes and address of person who comes and address of person who comes and address of person who comes and address of person who comes and address of person who comes and address of person who comes and address of person who comes and address of person who comes and address of person who comes and address of person who comes and address of person who comes and address of person who comes and address of person who comes are address of person	1. Liszat	am 23a) (Ty	pe, Print) &	Low	Stre	et Al	revdeen 21001
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	1-0-				,
	Regist	Tal	SEP 1 4 20	105 Bleeve	N.	assure				

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Agnes Murray

ORIGINAL

				State of Maryland / Department of Health and	d Mental Hygie	ne
				1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)	Reg.	№2005 29845
_		Physici		Robenta Di Moore	2. Date of Death Month	Day Year O 2 3 TM
		/Medio Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De	eath	4c. County of Death
				5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H	2	Han Fore
		Funeral Director	П	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H	in. (Month, Day, Ye	9. Birthplace (State or Foreign Country)
		pur		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		
		Marylar fed at	to	MD N/A Edgewood		10d. Inside City Limits 1 ☐ Yes 2 ☑ 116
		ith the Ma or 28e-f	Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country?
10		s 23a		809 Olive Branch Court 21040		USA
R	(0	after death w or Items 23a miner must t	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 12. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.
C	003	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or Items 23a or 28e-f show event, the Micdical Examinar must be notified at	ρ	3 ☐ Wildowed 4 ☐ Divorced Year or Dates:		Specify: Black
0	15-	in 72 ł	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of wife. DO NOT use retired)	working 16b	b. Kind of Business/Industry
	212	e filed within II Hygiene. other then "	E O	Elementary/Secondary (0-12) College (1-4or 5+) Z Techicom		Dental
	and	ould be file Mental Hy arked oth	Be		lame (First, Middle, Maid	ė i
	Maryland 21215-0036	2 should be and Mental is marked or eumatic ev	2	19a. Informant's Nam Relationship (Type, Print) 19b. Mailing Address (Street and Number or		ity or Town, State, Zip Code)
5		as 1 and 2 should of Health and Mer litem 27 is marker other treumatic		Bruce L. Moore/Hosbum 809 Olive Bro	mch Cour	+ Bogewood4021040
1/0	Baltimore,	Pages 1. nent of He int: if iten		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Place of Disposition (Name of cemetery, crematory or other place)	Date 200	Location - City or Town, State
15/6	Itim	≻ 65 ⊃		'4 Donation 5 Other (Specify) Bay view wearchry 9 21. Signature of Funeral Service Licenties 22. Name and Address of Facility	110/05 13	Saltimore, MO
•	Ba	permit. Departi Importi any inj		Hari Pi Cho	se Funer	al Service, P.A.
				23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.		Approximate Interval Between
		Pnysician /Medical		resulting in death)	RAIN	9nset and Death Syears
13	ě	Examiner		Due to (or as a consequence of): Sequentially list conditions b.		
159	18	ba sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury		
0645	/	be executed iicien and burial-transit	Examiner	resulting in death) Last c. Due to (or as a consequence of):		
#	8760	cate be exphysicien the buria	dlcal	d		
17	9	n certifica anding pl use as t	/Med	IF FEMALE: 23b. Was decoded program: 23c. If yes, outcome of pregnancy	-	
	Вох	death certif e attending d for use as	by Physiclan/Me	in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Vas 2 New 4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year
	P.0.	that the deed by the detached	Phys	9 □Unknown		
		The law requires that the death certificate tite has been signed by the attending physbage 2 should be detached for use as the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
Roberta	Vital Records,	w requires been sign should be	Completed		24a. Was an	
a	l Re		omp		- autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
Sob	Vita	Physician: The this certificate har director, page	Be	examiner?	eath (Check only one)	
	of	Phys this ral di	. To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	Home 5 Residence	
ยู่	ion	Attending Ph r death. ector: After th by the funeral	atlo	Accident investigation M 1 Yes 2 No		
Moore,	Division	or Atter de Director in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St	and Number or Rural Route Number, tate)
3		spitet		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla	ice, and due to the cause	e(s) and manner as stated.
		To the Hospitel or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death ocone) and manner stated.	curred at the time, date	and place, and due to the cause(s)
4	\	To Too	2	29b. Signature and title of poertifier 29c. License number	29d.	Date signed (Month, Day, Year)
		5		30 Name and address of person who completed pause of death (Item 23a) (Type, Print)		2 p7 L V Dev 7 2005
				DR. STANLEY KNAN 1308 BUSINESS CT WY #1	02 Edge	wood 21040
		Sta Registr		31. Date filed (Month, Day, Year). SEP 1 2 2005	-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29846 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 835 PN Epitember 2005 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Perring Parkwan NUTSing Facilita Parkville Homore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Sept. 30, 1909 6. Sex 7. Age (In-yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1₩ 2□F Mary I and Yrs. Director 214-03-4271 95 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If ten 27 is marked other than "natural", or Items 23s proper any injury or other traumath. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Director N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 2721 Kildaire Drive U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1944–1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Lithographer National Can Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Peter McEvov Anna Karstel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald McEvoy- Son 9304 Luray Drive Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 9/12/05 Baltimore, Maryland Heather Cain 22. Name and Address of Facility Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licensee 5305 Harford Road Baltimore, Maryland 21214 a 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ardio Vascular Dispas **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Certification: To Be Completed by Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-tran signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 1 Yes 2 No 2/2(No 1 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending investigation 1 Natural 1 Yes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident the 3 🗌 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide Hospital time Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Fune completely f (Check only onel and manner stated To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Sentember 9 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nobel Feinberg amaritan Hospital Bof Bu 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

4 2005

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Yeer **Physician** MARY 12:30 PM MACK 08 09 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE CITY JOHNS HOPKINS BAYNEW MED CATE BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F 85 162-12-7008 19,50 Pennsylvania Director Usual Residence of Decedent death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examinar Fuel by notified at 1 ☐ Yes 2 XNo Directo Dundalk Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21222 United States 1700 Kirkland Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 💹 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: by 3 Widowed 4 Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 Years permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic avent, SINB. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Raphael Biscardi Dominic Stravalo 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1700 Kirland Road Dundalk, Maryland Mr. Charles K. Mack (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gdns. 9/12/2005 Middle River, MD ~4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenspe 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Pent Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** BUSTIVM DRGAIN FAILURG SYAC EI disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner OBSTRUC SMALL BOMEC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner the attending physician and thed for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DEMENTIA, HYPGRYENSION 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an has autopsy certificate 2 2 No 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA this in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a McCertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 00/08/2005 431299 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins Bayview Medical Ctr. KEVIN B. GEROLD 120 4940 Eastern Ave. Baltimore, Maryland 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year BERT MILLER 7:50 PM SEPTEMBER. 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPITAL BALTIMORE ENTER H Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Dec 10, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 ₹M 2 ☐ F Months Director 214-78-2277 Usual Residence of Decedent death with the Maryland 10a State 10b. County Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Mudical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2 ☐ No Anne Arundel Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 899 Cecil Avenue Funerai 21108 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status unk Pages 1 and 2 should be filled within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Itel 1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 unk 1 ☐ Yes 2 ☑ No Specify: þ If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 11: (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harbor Hospital 3001 S. hanover Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. '4 □Donation 5 ☑Other (Specify) in state 21. Signature of Funeral Service Licensee

Renald S Wa 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASPIRATION PNEUMONITIS /Medical Due to (or as a consequence of): Examiner OSTEOMYELTTIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Sit Hospital or Attending Physician: The law requires that the death certificate be executed and TYPERTENSION that initiated events resulting in death) Last Due to (or as a consequence of): nding physician a Box 68760 Physician/Medical DIABETES MELLITUS IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I 9□ Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by TARDATION 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No t√ Impatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death Medical Certification: 28b. Time of 28d. Describe how injury occurred 14 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) di SEPTEMBER 4,2005 MEDICAL INTERN RESOOD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RA CHANT PALNITKAR SOUTH HAWOUER STREFT BALTIMORE, MARYLAND 31. Date filed (Month, Day, Year) SEP 1 4 2005 32/Registrar's Signature State Registrar

			For State Registrar	State of M	laryland		artment of rtificate or				iene _{eg. No.} 20	05	29849
	Physici		1. Decedent's Name (First, Midd. ALLE	- 11	42	-70				2. Date of Dear Month	th Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institutio	·			4b. City, Town,	or Location	of Death	S EPTENDE	4c. County	of Death	*
			NEATHWEST	HESPITAL				NAUS			BALL	The	RE
	Funeral Director		5. Social Security Number 7 218-14-8707	6. Sex 1 M 2 □ F	ge (In yrs. la:	st birthday) Yrs.	If Under 1 Yea Months Day		Min.	8. Date of Birth 0440nth 289,	Ĭ 9 24	9. Birthp Coun	lace (State or Foreign try) MD
	and w		Usual Residence of Decedent 10a. State 10b. County	у	10c. City,	Town or Lo	ocation					1	0d. Inside City Limits
	Mary a-f sho	tor	MD E	BALTIMORE		BALT	IMORE						1 ☐ Yes 2 No
	ith the	Director	10e. Street and Number				10f. Zip Code).		1	0g. Citizen of V	Vhat Coun	•
	s 23a	erai	2710 WILLOW (GLEN DRIVE 12. Was Decedent	· Sues in II S	12	Man December of	212			14 900	e - Americ	USA
က	or Item	Funeral	1 ☐ Never Married 2 💢 Mar	rried Armed Forces'	?		Was Decedent of If Yes, specify Cu			Rican, etc.)		k, White,	etc.
ğ	ural', c	d by	3 Widowed 4 Divorced		:		1 ☐ Yes 2 🔀 N		•		Specify	•	WHITE
7	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show the Mudical Exterili et rival be notified at	olete	(Specify only highe	nt's Education est grade completed)		(Give	dent's Usual Occ kind of work don DO NOT use retii	e durina mos	st of work	ing	16b. Kind of Bu	siness/Ind	dustry
21215-0036	d with giene.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	CONT	RACTOR				SELF EN	1PLOY	ED
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, If a Mudical Exacting coast be notified at ance.	To Be (17. Father's Name (First, Middle, BENJAMIN	, Last)		MAZE	.R		er's Nam ESSI	e (First, Middle, i E	Maiden Sumam	e)	GROSS
Man	d 2 sho h and 7 Is mu traumu	1	19a. Informant's Name/Relation:				-			a <i>l Route Number</i> E – BAL T			·
	s 1 and f Healt item 2 other		JOAN MAZER / 20a. Method of Disposition			ce of Dispo	osition (Name of matory or other p				20c. Location -		
altimore,	Page nent o ant: If ary or		1 🕅 Burial 2 □ Cremation 1 4 □ Donation 5 □ Other (\$		9	-	OH CEME		09/1	3/2005	100W	LAWN	, MD
Balt	permit. Departr Importa any inji		21. Signature of Funeral Service	Licensee						L LEVINS			
	40=40		23a. Part1. Enter the disease, of	or complications that cause	ed the death.							LL,	MD 21208 Approximate
	Physician		shock, or heart failure. Lis Immediate Cause (Final	st only one cause on each	line. VD S [4		RENT				001,		Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	d	s a conseque				-201	175			
	Cxammer	J.	Sequentially list conditions,	b. — Due to for a	s a consuque	nes sti							
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events	}	- a - a - a - a - a - a - a - a - a - a	37.00 31).							
Ö,	e exec ian an urial-tr	Exa	resulting in death) Last	Due to (or as	s a conseque	ence of):						Щ	
8760,	rcate be executed physician and s the burial-transit	dicai		d									
Box 6	leath certific attending pl	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Dat	e of delive	rv
o.	The law requires that the death certificate be executed tie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown			⊒Ectopic pregnan ∃ Other (<i>specify</i>)	cy			Mor		Day Year
Vital Records, P.	luires that a signed b	by	Part II. Other significant condition ANTENNO SCLORE	TIG CHAD	OVAS	antas	nderlying cause of		l.	23e. Did tol	/		e cause of death? ably 4 Unknown
900	e law requir has been si je 2 should	Completed	my te prolit	ERATIVE D	send	25				24a. Was a		Vere autor	osy findings available
Ä		Сош	INSULIN DE	PENDENT	Dep	be Tes	melle	وتديع		perform	ned?	eath?	2010
Vita	ysiclen: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hoopital						h Check on on			
of	등 등 등	n; To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Inj	jury 2	28b. Time o		ury at		me 5 🗌 Reside 28d. Describe ho			')
sion	ttending F death, stor: After / the funera	atio	E - 1.00.00111	tigation	ay rear)	Injury		ork? ⊒Yes 2 □	No				
Division	l or Atten after deati Director:	ertification;	3 Suicide 6 Could 4 Homicide determ	mined 286. Place of Ir	njury - At hometc. (Specify)	ne, farm, sti	reet, factory, office	9		28f. Location (St City or Town	reet and Number, State)	er or Rura.	l Route Number,
	e Hospital or 24 hours afte e Funeral Dir letely filled in	O	29a. Certifier 1 Certifyi	ing Physician: To the bes	it of my know	ledge, deat	h occurred at the	time, date ar	nd place,	and due to the ca	ause(s) and ma	nner as st	ated.
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	edical	(Check only 2 Medica	and manner s	of examination	on and/or in	vestigation, in my	opinion, dea	ath occur	ed at the time, d	ate and place, a	ind due to	the cause(s)
	To the I	7	29b. Signature and title of certific	or De la C				nse number		2	9d. Date signed	(Month, I	Day, Year)
	N		30. Name and address of person	n who completed cause of	death (Item	23a) (Tupo	Print)	1/20		عد ہے ،	apten	C.	27,2005
,)		GRIANDO R	3 - Continan) mis		· rony	Reta	Spalls	town	puone	land	29,2005 NEW 21133
	Sta		31. Date filed (Month, Day, Year CFD 1	4 2005 32. Régist	trar's Signatu	ire	asses?						
	Registi	ar	JEF I	I COOL	HARA S	- Pil							

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 04.48AM September **Physician** 13 Wanda 2005 Malczewski /Medical City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Bayview Baltimore Johns Hapkins 8. Date of Birth (Month, Day, Year) 1919 If Under 1 Year | If Under 24 Hrs. 9. Birthplece (Stete or Foreign Country) Maryland 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1□M 21√F 86 Director 213-09-5317 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r is marked other than "naturel", or Items 23a or 28e-f show traumatic event, the Mudical Examinar must be notified at 1 Yes 2 □ No Director Baltimore NA Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21224 6620 ODonnell Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours efter 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) filed withi Hygiene. Own Home NA Home Maker d 2 should be filed with and Mental Hygier 7 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Amiela Malecs Wojcik John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peges 1 end 2 ment of Health a lant: If item 27 is ury or other tree 22051 Bearen Drive Denton, Maryland 21629 Leonard Malczewski (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Holy Rosary Cemetery 16,2005 1 Burial 2 □ Cremation 3 □ Removal from State permit. Pego Department Important: If eny injury o 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, Maryland 22. Name and Address of Facility.
W. Dabrowski/Chojnacki Funeral Homes P.A. 21. Signatury of Funeral Service Line 23a. Zart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximate shock or heart failure. List only one grouse on each line. Immediate Cause (Final disease or condition resulting in death) Seotic **Physician** Shock /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificete be executed Due to (or as a consequence of): P.O. Box 68760, ettending physicien Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fetopic pregnancy Year ò in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 □ Yes 2 □ No. been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 🗆 No atnoventricular 3 Probably 4 □Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has be trector, page 2 s autopsy 2 No 1 ☐ Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Minpatient Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ပို 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; the Funeral Director: After appearant filled in by the funerant 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours after To the Funerel Dire Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier September 13, 2005 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins Bayrier Hopela 4940 Easker Avery, Baltimar, Mo 21224 31. Date filed (Month, Day, Year) SEP 1 4 2005 State

Registrar

			For State Registrar			Marylan	d / Depa	artmen rtificat	t of H	ealth a	and M		Reg. No.	200	5	298	51
	Physici	an	1. Decedent's Name (n Nasher							2. Date of De Month	Day	Yea	r	3. Time of De	
fit.	/Medic Examir		4a. Facility Name (If no			ber)		4b. City,	Town, or	Location of		Septemb		L, 200		6:45	p ^m
	Exami	iei			morial Ho				ederi					Freder			
	Funeral		5. Social Security Num			. Age (In yrs. I		If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da FEB. 2,	h y. Year)	9. B	irthpla Country	ce (State or Fo	oreign
1	Director		212-03-8 Usual Residence of De	001	1□M 2\ F	88	Yrs.					FEB.2,	1917			MD	
	yland yow			0b. County		10c. City	y, Town or Lo	ocation							100	I. Inside City L	_imits
	the Marylar 28a-f ehow	ctor	MD	FRE	DERICK		FRED	ERICK								1 X Yes 2	□No
	filed within 72 hours after deeth with the Maryland Hygiene. ther then "naturel", or Iteme 23a or 28a-f show int, I're Medical Exartiral frant be rediffed at	Funeral Director	10e. Street and Numb		_			10f. Zip	Code				10g. Citiz	en of What			
	eeth v	eral	608 BIGG	S AVENU	12. Was Deced	lant Ever in 11	C 12	Was Dage	dont of U	2170		acti Vac as Na		4. Race - An		USA	
10	fter d	F	11. Marital Status 1 Never Married	2 X Married	Amed Ford	es? XINo				n, Mexicar	n, Puerto	ecify Yes or No Rican, etc.)	1	Black, Wi			
036	rel', o	ρ	3 Widowed 4	Divorced	If Yes, Give Year or Dat	1		1 🗌 Yes	2 X) No	Specity:				Specify:		WHITE	
21215-0036	72 h	Completed	15 (Specify	only highest gr	ducation ade completed)		16a. Dece (Give	dent's Usua kind of wo DO NOT us	al Occupa	tion u <i>rin</i> g mos	t of work	ing	16b. Kir	d of Busines	s/Indu	stry	
121	within ene. then	dm	Elementary/Second	ary (0-12)	College (1-	4or 5+)		MAKER)			OMN	HOME			
102	filed with Hygiene other the	Be Co	17. Father's Name (Fig.		7)		110112	, ,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		18. Mothe	er's Name	e (First, Middle,					
/lar	2 should be and Mental is marked o	To B	ABRAHAM				OREN	STEIN		FAN	NNIE					SILVER	
Maryland			19a. Informant's Nam									al Route Numbe				ode)	
	1 and 1 eelth om 27 ther tr		ARLENE F		DAUGHTER		3309 face of Dispo			F ROF		BALTIM(<u>-</u> _				
Baltimore,			1 X Burial 2 □	Cremation 3	Removal from S	tate	emetery, cre	matory or o	ther place					ation - City o			
ij	permit. Page Depertment Important: It eny Injury o		4 □Donation 5 21. Signature of Fune			RU	DFE ZE	DEK U						TIMOR			
Ba	permit. Depertr Importe eny Inji		10	al							301	LEVINS					2
4.3	ê.		23a. Part1. Enter the shock, or leart f	disease, or com	plications that ca	used the death								,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	A	pproximate iterval Betwee	
15	Physician		Immediate Cause (Fir disease or condition	nal	ac	ute	Per	tom	ite	,					2	nset and Dea	th
	/Medical Examiner		resulting in death)	(Due to (o	r as a consequ		00.75								ico Co	
*		je i	Sequentially list condi	tions,	b. — Due to (o	ras a consequ	uence of):								-		
	uted	Examiner	Sequentially list condi if any, leading to imm- cause. Enter Underly Cause (Disease or inju- that initiated events	ing ury	C.		,										
o,	ate be executed physicien and the burial-transit		resulting in death) Las	t I		r as a consequ	uence of):									-	
8760,	ate be thysici	lcal		•	d										-		
9	The law requires that the death certificate be executed ate hes been signed by the attending physicien and bage 2 should be detached for use es the burial-transit	Physician/Medical	IF FEMALE:		23c. If yes, outco	ome of preens	nov										
Вох	atten after of for u	clan	in the past 12 mg	onths?	1□Live bir	th 2 Fetal	death 3	Ectopic pr					2	3d. Date of d Month	elivery Da	ay Year	r
0	that the de led by the a detached t	hys	1 ☐ Yes 2 ☑ N 9 ☐ Unknown	10	9 Unknov			3 011101 (0)									
S, P	res tha igned l be det		Part II. Other significa	int conditions	contributing to dea	th but not resu	ulting in the u	nderlying c	ause give	n in Part I.		23e. Did to	obacco us	e contribute	to the	cause of deatl	h?
Records,	w require been si should b	Completed by	Cerency	le	leny (/see	Relp					1 🗆 Y	es 2.	HV0 3□1	Probab	ly 4 🗆 Unkr	nown
ec	ne taw i hes be ge 2 sh	nple	algher	nec	Oen	ester	5					24a. Was autop	SV	24b. Were a	autopsy	findings availetion of cause	ilable e of
al H	t: The												med?	death?	,	□ No	
Vital	ysician: The is certificate he director, page	Be	25. Was case referred examiner?		Hospital:	,			Othe	-		(Check only o					
of	무 등 등	: To	1 Yes 2 No		28a. Date of (Month		ER/Outpatier 28b. Time o		8c. Injury Work	4 11 140		me 5 Resid			ecify)		
ion	ittending F death. ctor: After / the funer	atlo	1 ENatural 2 ☐ Accident	5 Pending investigation		, Day Year)	Injury	м		? ′es 2 □ l	No						
Division	r Atte ler de irecto	Certification:	3 Suicide 4 Homicide	6 Could not be determined	280. Place C	of Injury - At ho	me, farm, str	eet, factory	, office			28f. Location (S City or Tow		Number or I	Ru <i>ral F</i> i	oute Number	
	urs ef	Cer															
	To the Hospital or Attending Physician; within 24 hours effer death. To the Funeral Director; Affer this certified completely filled in by the funeral director, t	edlcal	29a. Certifier 1[(Check only 2[one)	Certifying Pl Medical Exa	hysician: To the b miner: On the bas and manne	sis of examinat	wledge, deat tion and/or in	h occurred vestigation,	at the tim in my op	e, date and inion, deal	d place, th occurr	and due to the d ed at the time, d	date and	and manner a place, and du	as state	ed. e cause(s)	
	ro the	Me	29b. Signature and titl	e of certifier	andmanne	or stated.		290	. License	number			29d. Date	signed (Moi	nth, Da	y, Year)	
	. > - 0		The same	~ E	Be	les 1.	no	1	030	04%	96		5,	1/2/0	5	-	
1	N		30. Name and address	of person who	completed cause	of death (Item	23a) (Type,	Print)		r = 1 +		/	,	/-	-		
1	U		Francis /2	. Be	eken 1	30	300	14 9	1-1-	1/	re	Lerid	- K	11/21	170	7 <i>j</i>	
	Sta Regist		31. Date filed (Month,	SEP"1	20.05 32. 8	gistrar's Signat	ure /	GD184EA	Section 1								

			State of Maryland / Department of Health and 1- State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)	R 2 Pata of Page	eg. No. 200	5 29852
	Physici /Medic		Caroline Naylor	Septem4	9 11 2005	
	Examin	er	4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL CENTER RANDALLSTO	WN	BALTIN	th 10RE
Ī	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) H Under 1 Year If Under 24 Hr. 28 F 90 Yrs. Months Days Hours Min		9. Bir 1914 V T	thplace (State or Foreign ountry)
	ow other		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	he Mary 8e-f sh	ector	MD CARROLL SYKESVILLE			1 ☐ Yes 2 No
	23e or 2	al Dir	7200 THIRD AVENUE 10f. Zip Code 21784	i	0g. Citizen of What C USA	ountry?
036	urs after dea el', or items Examination	by Funer	11. Marital Status 1 Never Married 2 Married 1 Never Married 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puell Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puell Yes, Give Year or Dates:	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Whi Specify: W	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "neturel", or items 23e or 28e-f show important: if item 27 is marked other than "neturel", or items 23e or 28e-f show ally injury or other treumatic event, the Modeal Examination until or multiplied at another.	Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work done) (Iffe. DO NOT use retired) LIBRARIAN	orking	16b. Kind of Business	
Maryland ;	should be filed and Mental Hyge marked othe umatic event,	To Be C	WARREN BENYEW DUNHAM MARGEN	ame (First, Middle, I IE DUNHA)		
	and 2 sho salth and n 27 is mu		19a. Informant's Name/Relationship (Type, Print) ALAN JOHN NAYLOR son 19b. Mailing Address (Street and Number of Relationship (Type, Print)) 19b. Mailing Address (Street and Number of Relationship (Type, Print))			
Baltimore,	Pages 1 and neut of Heamont: if item		20a. Method of Disposition 1 Burial 2 Tremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or	
altin	permit. Pa Departmer Importent any injury once.		*4 □ Donation 5 □ Other (Specify) GREEN MOUNT SEF 21. Signate 6 of Fun neal Service Licensee 22. Name and Address of Facility HE		005 BALT JENKINS	
B B	88 28		23a Party Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardia			111 Approximate
	Physician /Medical		23a. Park Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	moria		Interval Between Onset and Death
	Examiner	16				
	acuted ind transit	amine	cause. Enter Undertying Cause (Disease or injury that initiated events c			
8760,	ate be executed hysician and the burial-transit	cal Ex	Due to (or as a consequence of):			
P.O. Box 68	ath certific ittending pl or use as t	Physiclan/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown		23d. Date of de Month	ivery Day Year
	juires that the de n signed by the a ild be detached f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic atrial fibrulation, Hypertension, Gasto interinal scentification		pacco use contribute to	the cause of death?
of Vital Records,	The law requires ate has been sign page 2 should be	Completed by	Gastrointesinal blearing	24a. Was as autops perform	y prior to	utopsy findings available completion of cause of
Vita	icien: certific rector,	o Be (examiner?	eath (Check only on	θ)	
ion of	Jing After fune	Certification: To	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? M 1 Yes 2 No		nce 6 □ Other (Spe w injury occurred	city)
Division	i or Att after de i Direct d in by t	ertific	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Sti City or Town	reet and Number or Ri , State)	ıral Route Number,
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plac 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plac 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examiner and the place 2 medical Examiner and the place 2 medical Examiner and the place 2 medical Examiner and 2 medical E	e, and due to the ca urred at the time, da	iuse(s) and manner as ate and place, and due	stated. to the cause(s)
}	Within Comp	M	29b. Signature and title of certifier Daywayay MD 29c. License number 0 5 4288		Sept 114	
9)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rame way Danger Governor Northwet Hypulat G		-	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 4 2005	,		

DHMH 17 Rev 1/2001

067		1 - For Unpend Item 23 Registrar 1. Decedent's Name (First, Middle, Last		ryland / Dep ,27 per inc Ce	artment of rtificate	of Death	d Mental Hyg	-3			
Physic /Medi Examir	cal	Shawn Opher 4a. Facility Name (If not institution, give	street and number)			wn, or Location of E	SEPTEMB1	Day Year	3. Time of Death 2340 P M		
Funeral Director		UNIVERSITY HOSPIT 5. Social Security Number 6. Se 218-86-7741 Usual Residence of Decedent		(In yrs. last birthday) 33 Yrs.	If Under 1 Y		Hrs. 8. Date of Birth (Month, Day) 11–28–197	Year) 9. Birth Cou	place (State or Foreign ntry) Land		
he Maryland 28a-1 show	ector	10a. State 10b. County MD NA 10e. Street and Number		10c. City, Town or Lo	altimore				10d. Inside City Limits 1 Yes 2 No		
ine, intelly ideal of LETS-0000 s 1 and 2 should be filled within 72 hours after death with the Maryland if Health and Mental Hygiene. Itsm 27 is marked other then "natural, or items 23s or 28s-1 show other traumatic event, the Medical Expollment rental termotified at	/ Funeral Director	611 Gold Street 11. Marital Status 1 🖫 Never Married 2 🗆 Married	12. Was Decedent E Armed Forces? 1 ∐Yes 2 🖔 N If Yes, Give		Was Deceden	21217 t of Hispanic Origin Cuban, Mexican, P	? (Specify Yes or No-	0g. Citizen of What Cou USA 14. Race - Ameri Black, White,	Can Indian,		
portrill (15) Wall yield a file (15) Jours at permit. Peges 1 and 2 should be filed within 72 hours at Department of Health and Mental hygiene. Important: If Ism 27 is marked other then "natural", or may highly or other traumatic avent, the Medical Exact page.	Completed by	3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 10	Year or Dates:	(Give	dent's Usual C	occupation fone during most of	working	Specify: Bla			
should be filed and Mental Hygis smarked other iumatic sysnt, ii	To Be C	17. Father's Name (First, Middle, Last) Percy Opher				Chris	Name (First, Middle, I tine Monroe				
jes 1 and 2 st of Health and if Itsm 27 Is nor or other traun	- NO.	19a. Informant's Name/Relationship (7) Christine Monroe/Mot 20a. Method of Disposition 1 Burial 2 (XCremation 3 DF	her	611 (Gold Stre	eet Baltimo:	re, MD 2121	, City or Town, State, Zij 7 20c. Location - City or Ti			
permit. Peges 1 an Department of Heal Important: If Itsm 2 any injury or other		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Wetro Crematory 09-09-05 Catonsville, MD 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor St. Balto,									
Physician /Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Cardiac a Due to (or as a Due to (or as a Due to (or as a	Э.	sion	f dying, such as car	diac or respiratory arre	ost,	Approximate Interval Between Onset and Death		
The law requires that the death certificate be executed to has been signed by the attending physicien and loge 2 should be detached for use as the burial-transit	by Physician/Medical	in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions con	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at t 9 Unknown	of pregnancy 2 Fetal death 3 Ime of death 5	Ectopic pregn Other (specifinderlying caus	ý)		23d. Date of delivered Month	Day Year ne cause of death?		
n: The law require ficete has been sign, pr. pege 2 should b	e Completed	Chronic narcotism, 25. Was case referred to medical	astnma				24a. Was ar autops:	24b. Were auto prior to co death?	psy findings available mpletion of cause of		
To the Hospital or Attending Physician: The law requires I within 24 hours after deeth. To the Funeral Director: After this certificete has been signe completely filled in by the funeral director, page 2 should be	Certification; To Bo	examiner? 1 Xes 2 No 27. Manner of Death 1 Xetural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	lospital: 1 Inpatien 28a. Date of Injury (Month, Day	Year) 28b. Time o	f 28c.	Other: 4 Nursin	28d. Describe ho	nce 6 Other (Specifi w injury occurred			
To the Hospital or Attance within 24 hours after deelf to the Funeral Director: completely filled in by the	edical	4 Homicide determined 29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	building, etc.	my knowledge, deat	h occurred at th	ne time, date and n	City or Town	eet and Number or Rura State) use(s) and manner as s te and place, and due to	e a tad		
To 1 with To 1	W	29b. Signature and title of certifier 30. Name and address of person who	mpleted cause of de	ath (Item 23a) (Type,	Print)	ocmE	2	d. Date signed (Month, SEPTEMBER 5	Day, Year) 2005		
Sta Registi		JAW M 73 31. Date filed (Month, Day, Year) SEP 1 4 20	4/ M.D. 32. Haistrai	111 PEN	N STREE	T, BALTI	MORE, MARYI	AND, 21201	20/8/10/20 TO 16/10/20 TO		

Physici	an	Decedent's Name (First, Middle, Last	•							Date of Dea Month eptemb		- Year	3. Time	а D Q п О
/Medi	cal		ULPHUS			41 C' T				ebremi				T É W
Examir	ier	4a. Facility Name (If not institution, give 7888 Tall Pines		pt.	В	Glen		Location of nie	Death			ounty of Dec ne Art		
Funeral Director		5. Social Security Number 6. Se 354-58-5459 15 Usual Residence of Decedent	X 7. Ag ☐ M 2☐ F XX	e (In yrs. 45	last birthday) Yrs.	If Under 1 Months	Year Days	If Under 24 Hours	Min. D	Date of Birt (Month, Day C 27,	h y, Year) 1959	9. Bi Mi	rthplace (State Sountry) SSISSI	te or Foreign .ppi
Mo w		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside	City Limits
a-l-a	to	Maryland Anne Ar	undel	G]	len Bui	nie							¹₩X	es 2 □ No
ene. then "naturel", or items 23e or 28a-1 ehow ne Moulcal Extrainer must be notilied at	Dire	10e. Street and Number	7	D		10f. Zip C						n of What C	ountry?	
18 23¢	Funeral Directo	7888 Tall Pines Co	12. Was Decedent		S 13 V		061	oanic Origi	n2 /Specif	y Vas or No.		.S.A.	erican Indian	
Department of health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel; or Items 23s or 28s-1 show my injury or other traumatic event, the Medical Examiner must be notified at ance.	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			Was Decede f Yes, specif 1 ☐ Yes 2		Specify:	Puerto Rio	an, etc.)	1	Black, Wh	ite, etc.	
"netri	Completed	15. Decedent's Edu (Specify only highest grad			16a. Deced	dent's Usual kind of work DO NOT use	Occupa done di	tion uring most o	of working		16b. Kind	of Busines	s/Industry	
then.	mpi	Elementary/Secondary (0-12)	College (1-4or 5	5+)		oo nor use cicide					Stat	e Hiq	hway	
other ent, II	Be Co	17. Father's Name (First, Middle, Last)	Z years		2000				s Name (F	irst, Middle,			ay	
arked o	To B	John B. Kimble						Lill	ie C	raig				
ie ma		19a. Informant's Name/Relationship (T)				ng Address (
m 27 her tr		Natoya Pulphus -	daughter	look B	302 F	CONTRACTOR OF THE PARTY.		orive,					MD 210	
tent: If its jury or of		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,)	0	emetery, crem Natior	natory or oth nal Cei	nete	ery 09		05	Laure	1, MD	r Town, State	
any in		21. Signature of Funeral Service Licens		00770		oonaid 313 Ta						2070	7-4389	
edical eminer	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Atheroso Due to (or as b. Due to (or as	ne. lero a conseq	tic Ca uence of):								Approxim Interval E Onset an	Between nd Death
attending physician and I for use as the burial-transit	Physician/Medical Ex	in the past 12 months?	Due to (or as d	of pregna	incy	Ectopic preg					230	I. Date of de	elivery Day	Year
ed by the a	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	time or u	eatti 5	JOther (spec	п у)							
been signed t should be det	۵	Part II. Other significant conditions co	ntributing to death b	ut not resi	ulting in the ur	nderlying cau	se give	n in Part I.		23 <i>e</i> . Did to			o the cause of	
ate has paga 2	Completed								_	24a. Was a autop perfor 1 Yes	sy	4b. Were a prior to death?	utopsy finding completion o	gs available if cause of
is certifical director, p	Be	25. Was case referred to medical examiner?	Hospital:				7			check only or				
After this funeral di	ation: To	1 Ness 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ry	ER/Outpatien 28b. Time of Injury		Other	4 [] 14u13	280	5 🗌 Resid			ecify)at s	cene
I Director: d in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc.	ury - At ho c. (Specify	ome, farm, stre	eet, factory, o	office		28f	Location (S City or Tow		lumber or R	ural Route Ni	umber,
To the Funaral Direct completely filled in by	ledical C	29a. Certifier (Check only one) 1 ☐ Certifying Phy (Check only one)	sicien: To the best iner: On the basis of and manner sta	examina	wledge, death tion and/or inv	occurred at restigation, in	the time my opi	e, date and inion, death	place, and occurred	due to the d at the time, d	ause(s) and pla	d manner a ace, and du	s stated. e to the cause	θ(s)
To the Fu	W	29b. Signature and title of certifier	AN	1				number M.E.		à		_	th, Day, Year, 12, 20	,

			1- For State of Maryland / Department / Department / Depa	artment of Health and M rtificate of Death	, ,	ene . No 2005	29855
	Physic /Medí Exami	cal	Decedent's Name (First, Middle, Last) Maxine L. Pearl 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	2. Date of Death Month September	Day Year 2005	
	Funeral	lei	Continuum Care At Sykesville 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Sykesville If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	4c. County of Death Carroll 9. Birth	pplace (State or Foreign
	Director Modular		487-40-1061	ocation	Dec 10 19	937 Ark	ansas 10d. Inside City Limits
	with the Ma 3a or 28a-f s t be notified	i Directo	10e. Street and Number 5116 Gold Hill Road	10f. Zip Code 21117	10g.	. Citizen of What Cou	1 ☐ Yes 2 No intry?
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show shy injury or other traumatic event, Ira Modical Examiner is ust be rotified at ance.	by Funeral Director	1 Never Married 2 Married 1 Yes 2 No	Use Decedent of Hispanic Origin? (Speif Yes, specify Cuban, Mexican, Puerto Fill Yes 25¼ No Specify:	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Wh	, etc.
21215-0036	ed within 72 h ygiene. nar than "natu t, II e Medical	Completed	Elementary/Secondary (0-12) College (1-4or 5+) bank	dent's Usual Occupation kind of work done during most of workin DO NOT use retired) Imanager	ng	inancial	idustry
Maryland	should be fill and Mental H in marked oth	To Be	17. Father's Name (First, Middle, Last) Mack Littlejohn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	18. Mother's Name Pearlie Ing Address (Street and Number or Rura)	Simons		0.41
	Pages 1 and 2. nent of Health ar int: If Item 27 is iry or othar trau		John J.Pearl (son) 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposemetery, crem	lawk Ridge Lane, Sy sition (Name of natory or other place)	kesville	, Md 21784 Location - City or To	own, State
Baltimore,	permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Service Licensee	y Cremation 9-14-0 Name and Address of Facility Hai O. Box 195 Sykesvi	ght Fune	kesville, ral Home 8	
8760,	Physician buy sician and physician and physician and physician and physician site private is the private that the private tha	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	er the mode of dying, such as cardiac or SC Amyot Sclerusss	respiratory arrest,		Approximate Interval Between Onset and Death
.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of delive Month	ary Day Year
ords, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.		co use contribute to the	ne cause of death? ably 4 □Unknown
Vital Records,		e Completed	25. Was case referred to medical		24a. Was an autopsy performed?	? prior to condeath?	psy findings available inpletion of cause of
Division of Vi	Ing Phys After this uneral di	ertification: To B	examiner? 1)
Divi	pital or urs afte aral Dir.	O	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge death		City or Town, Sta	,	
	To the Hos within 24 ho To the Funa completely f	Medical	(Chack only 2 Medical Eveninas O. II.	occurred at the time, date and place, an astigation, in my opinion, death occurred 29c. License number	d due to the cause d at the time, date a	e(s) and manner as stand place, and due to Date signed (Month, L	the cause(s)
) 	1		30. Name and address of person who completed cause of death (Item 23a) (Type, P	D-0054 2	218 0	9-13-	2005
	Sta		29b. Signature and title dicertified 30. Name and address of person who completed cause of death (Item 23a) (Type. P 31. Date filed (Month, Day, Year) SEP 1 4 2005	Malcalm dur	re, Wes	rmine fer	TYP
	Registr	ar	OEL T # FOAD AND AND AND AND AND AND AND AND AND A				

	.100	-	For State Registrar	State of Maryla	nd / Dep <i>Ce</i>	artment of F	lealth and <i>Death</i>		Reg. No.	2005	29856
	Physicia /Medic Examin	an al	Decedent's Name (First, Middle, Las Daniel Chapman Aa, Facility Name (If not institution, give	Robinson		4b. City, Town, o	or Location of Dea		ber ^{Day} 9	, 2005	3. Time of Death 12:30 p. M
	Funeral Director	GI	1046 North Luzerr 5. Social Security Number 250-38-8940-A 7	ne Avenue	s. last birthday, Yrs.	Baltin If Under 1 Year Months Days		n. (Month, Da		11timor 9. Birtho Cour 1932 F]	re place (State or Foreign plry) S. Caro. Lorance
	Ţ.	tor	Usual Residence of Decedent 10a. State 10b. County Md. Baltime	10c. C	City, Town or L	ocation Bal		, Mary			0d. Inside City Limits 1 XYes 2 □ No
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 ie marked other than "natural", or liteme 23s or 28s-f show other traumatic event, Ite Mydical Examinar must be notified at	by Funeral Director	10e. Street and Number 1046 North Luze 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Workproced	erne Avenue 12. Was Decedent Ever in Armed Forces? 1	U.S. 13.	10f. Zip Code 21205 Was Decedent of H If Yes, specify Cub	dispanic Origin? an, Mexican, Pue	Specify Yes or Norto Rican, etc.)	U. S	S • A • 4. Race - Americ Black, White,	can Indian, etc.
21215-0036	filed within 72 hours Hygiene. other than "natural" ent, the Medical Ex	Completed b	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12th.	ucation	(Give	dent's Usual Occup a kind of work done DO NOT use retire CK Masor	during most of w d)		16b. Kin	nd of Business/In ivate	
Maryland	should be file and Mental Hy marked oth umatic event	To Be	17. Father's Name (First, Middle, Last) Lavette Robins 19a. Informant's Name/Relationship (7		19b Mail	ing Address (Street	Lula	Chapmar	n Rok	oinson	o Code)
Baltimore, Ma	permit. Pages 1 and 2 shr Department of Health and Important: if item 27 ie m any injury or other traum once.		Daniel Charles 20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Denation 5 Other (Specify 21. Sign tree) Fungal Service Con	Robinson 200b.	100 Place of Disp cemetery, cre	7 Bladin osition (Name of matory or other pla acle Ban 2. Name and Addre	ot 205	et, Bea Date ept 105 Latney	aufor 20c. Loc s Fu	rt, S.C eation - City or To nufort, ineral	Carolina
3760, <	Physician Industrial I	lical Examiner	23a. Part1. Enter the disease or companies, hock, or heart failure. List only of the second state of the s	Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect.	equence of):						Initerval Between Onset and Death
P.O. Box 68	law requires that the death certificate es been signed by the attending physic should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	□Ectopic pregnand □ Other (<i>specify</i>) _	у		23	3d. Date of delive Month	ery Day Year
	quires that in signed by uld be deta	Ď	Part II. Other significant conditions of	ontributing to death but not re	esulting in the	underlying cause gr	ven in Part I.		tobacco us	_	he cause of death? pably 4 Unknown
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Division of Vital	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: To Be	25. Was case referred to medical examiner? 12 Yes 2 No 27. May ler of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)		of 28c. Inju	her: 4 🗆 Nursing	eath (Check only Home 5 Res 28d. Describe	idence 6 how injury	occurred	
Divi	spital or Att ours after d neral Direct filled in by	al Certif	4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	cify)		me, date and pla	City or To	iwn, State)		al Route Number,
	M	Medical	(Check only 2 Medical Examone) 29b. Signature and title of certifier	iner: On the basis of examinand manner stated.	nation and/or i	29c. Licen	opinion, death oc		, date and p 29d. Date		Day, Year)
	<i>'</i> b		30. Name and address of person who	completed cause of death (It		^{, Pg} ill Peni	n Street	Baltim	ore,	Maryland	d 21201
	Sta Regist	ate rar	SEP 1 4 2005	A .		dis					

DHMH 17 Rev 1/2001

ORIGINAL

Amend age Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	_	For State Registrar			artment of Health ar rtificate of Death	Reg.	2005	29857
Physicia /Medica	al .	1. Decedent's Name (First, Middle, Las Roxanne R	Roxane	e R.	Ryles	2. Date of Death Month Septemb	Day Year 9r 10, 2005	3. Time of Death
Examine Funeral	er	4a. Facility Name (If not institution, give Mercy Medica 5. Social Security Number 6. S	1 Center 7. Age (In yrs.	last birthday)			4c. County of Death	ace (State or Foreign
Director		Usual Residence of Decedent	DM 200F 50	Yrs.		SEPT. 05	,1955 MA	RYLAND
the Marylar 28a-f ehow notified at	ctor	10a. State 10b. County MARYLAND	IA 10c. City	y, Town or Lo	BALTIMO	ORE CIT	-y 10	od. Inside City Limits 1 Yes 2 No
uth with the	Funeral Director	10e. Street and Number 53/2 NEL	SON AVE	NUE	10f. Zip Code		Citizen of What Count	try?
urs a	2	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ② Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	- 1	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F 1 ☐ Yes 2 ♣ No Specify:	? (Specify Yes or No- querto Rican, etc.)	14. Race - America Black, White, e	
ithin 72 hours aff 16. 18n "natural", or 18. ofcal Ex. m	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occupation kind of work done during most of DO NOT use retired)	working 16b	o. Kind of Business/Indi	ustry
d 2 should be filed wit th and Mental Hygien. It is marked other th traumatic event, the	Re	12 +HGRADE 17. Father's Name (First, Middle, Last)		OF	A	Name (First, Middle, Maid		
12 should be n and Mental is marked of raumatic eve	9	19a. Informant's Name/pelationship (ype, Print)	19b. Maili	ng Address (Street and Number of		7	
es 1 an of Heel of Heel if Item 2		DORIS MODDY 20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	lace of Dispo emetery, cres	isition (Name of natory or other place) S (EMETERY 0)	Pate 200	BALTO, ML Location - City or Tow BALTIMORI	D, 2/2/60 vn, State E. HARVLAVL
permit. Pag Depertment Important: I any injury o		21. Signature of Funeral Service Licen	V. William	no o	Name and Address of Racility	BROWN TON AVE	1	ERALHOME
ate be sate be shysicis the bu	edical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of limediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Os piration Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	n pne uence of): atic uence of):	er the mode of dying, such as can EUMONI'A rectal car]]	Approximate interval Between Onset and Death
	Pnysician/me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2⊠ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy		23d. Date of delivery Month D	y Day Year
quires that	δ.	Part II. Other significant conditions or	ntributing to death but not resu	ilting in the u	nderlying cause given in Part I.	23e. Did tobacc	co use contribute to the	cause of death?
	Completed					24a. Was an autopsy performed 1 Yes 2	? death?	sy findings available pletion of cause of
Physician: The this certificeteral director, page		25. Was case referred to medical examiner?	Hospital: 📈		Othor	Death (Check only one)		
Phys eral di	0	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of	28c. Injury at	g Home 5 Residence 28d. Describe how in		
r Attending I er death. rector: After by the funer	Callo	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		Injury	Work? M 1 Tyes 2 No			
a 2 a 0	Cermication	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify			City or Town, St		
To the Hospital within 24 hours a To the Funeral I completely filled	ealcai	one)	sician: To the best of my know iner: On the basis of examinate and manner stated.	vledge, death ion and/or inv	occurred at the time, date and pi restigation, in my opinion, death o	ace, and due to the cause ccurred at the time, date a	e(s) and manner as stat and place, and due to the	ted. he cause(s)
To the within 2 To the complet	2	29b. Signature and title of certifier	Dota		29c. License number		Date signed (Month, Da	
3		Mudy So. Name and address of person who co University of Man	ompleted cause of death (Item	23a) (Type,	P18546) De	prember 1	0,2005
State		University of Man 31. Date filed (Month, Day, Year)	Jond Medicul	ysten ure	n, 22 South Gre	ene Street,	Baltimore	, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 5, 2005 **Physician** Charlotte Trail Rippeon 2:30 AMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 708 Fairview Avenue Frederick Frederick If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth July 23, 1929 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 215-26-7989 76 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f ehow 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examinar must be notified at Director Frederick Maryland Frederick Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 708 Fairview Avenue 21701 U.S.A. by Funerai 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Never Married 25 Married 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 11Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Roger L. Main Mamie Trail ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grayson E. Rippeon/Husband 708 Fairview Avenue, Frederick, Maryland 21701 20b. Place of Disposition (Name of Cemetery, crematory or other place)
Mt. Olivet Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5 Sept. 9, 2005 Frederick, Maryland permit. Page Department of Important: If any injury or once. Reeney and Basford PA Funeral Home 106 East Church St., Frederick, MD 21. Signature of Funeral Service Licensee M0Q021 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final DIFFUSE LAPBE CELL LYMPHOMA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician are the burial-t Division of Vital Records, P.O. Box 68760, use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐Unknown Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performed director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident after deatl Director: 3 🗌 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 | Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31761 September 6, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRESERICK MD ZITOI 501 W. SEVENTH ST. CONNER MD 31. Date filed (Month, Day, Year)
SEP 1 4 2005 3 Registrar's Signature State

Registrar

State of Maryland / Department of Health and Mental Hygiene 005 29859 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 9, **Physician** Nicholas Michael 9:50 P M 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 4919 Carroll Court Baldwin | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 24, 1916 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F 89 213-03-6471 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits show 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Baltimore Baldwin Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4919 Carroll Street 21013 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ՃYes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nit. Pages 1 and 2 should be filed within artment of Health and Mental Hygiene. ortant: If Item 27 is marked other than 'thjury or other traumatic event, Ite Ms Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver BGE Utility 5th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Guiseppe Rego Frances Recchione 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary P. Rego (wife) 4919 Carroll Court, Baldwin, MD 21013 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department Important: If any fnjury or once. Most Holy Redeemer 9/15/2005 Baltimore, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes Buin a Weller 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final - UNG CHAMPER **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physicien and hed for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? this certificate 2 🗆 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide ō Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29h Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0020673 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7602 Belain

Registrar DHMH 17 Rev 1/2001

State

George Lowf

SEP 1 4 2005

32. Registrar's Signature

ORIGINAL

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 29860 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Vonda Glenda Rame.u September 10,2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1011 Hignet Way Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1□M 2**X**)F Yrs Director 213-52-3479 April 28, 1947 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ral', or items 23a or 28a-f ehow Examiner must be nutified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1011 Hignet Way 21205 U. S. A. filed within 72 hours after death Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: à 3 X Widowed 4 ☐ Divorced White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 11th Grade Homemaker Own Home other 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be flit.
Department of Heelth and Mental Hy
Important: If Item 27 Ie marked oth
eny injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Oran Davis Helen Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 391 El Vista Drive, Hanover, Pennsylvania 17331 Janney D. Makowski (Dghtr) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 9/13/2005 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee Buan a Willen 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Onset and Death CANCER Pnysician 42AVS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Dualto (or se a consequence of) use as the burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 You 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Donknown peen Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3□ DOA in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) ALLA cul D44715 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAul BACT MD ZIZOZ 301 ST 111 egistrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene 0 0 5

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			1 - State Registrar	- Claic of Marylan	Cei	tificate of	Death		Reg. No.	003	
	Physici	an	1. Decedent's Name (First, Middle, L	ast)				2. Date of D Month	Day	Year	3. Time of Death
	/Medic		RAYMOND SPANN 4a. Facility Name (If not institution, gi	ve street and number)		4h City Town o	or Location of Dea	Septem		2005 ounty of Death	unk
	Examin	ıer	126 Scott St.			Baltimor				,	
_	Funeral			Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs		irth	9. Birth	place (State or Foreign intry)
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Š.	of Height	1 3	20a. Method of Disposition	20b. P	Place of Dispo	sition (Name of natory or other place	ce)	Date	20c. Loca	tion - City or T	own, State
altimore,	permit. Pages 1 Department of the Important: If its any injury or ot once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	BA'	_	CREMATORY	!)50914	BALT	IMORE.	MD
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õ	death cer	hysician	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3□	Ectopic pregnancy Other (specify)	′		230	I. Date of deliv Month	Day Year
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Sora	w require been sign							10	Yes 2 €1	No 3∏Prol	bably 4 □Unknown
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<u> </u>	i: The law icete has r, page 2 s							Yes Perf	ormed? 2 □ No	death? Yes	2□ No
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	To the Hos within 24 h To the Fur completely	Med	one) A 29b. Signature and title of certifier	and manner stated.		29c. Licenso				igned (Month,	
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	1.		30. Name and address of person who	completed cause of death (from	23a) (Type	O.C.M.	.E.		Septer	nber 11	, 2005
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			State of Manyland / Deportment of Health and Mantal Hydriana
			State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Certificate of Death Reg. No. 2005 29862
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Atlanta M. Scott 2. Date of Death SepTember 9, 2005 100 p M
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BAH: more
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1 M 2 F 8 Yrs. Months Days Hours Min. June 12 1924 9. Birthplace (State or Foreign Country) PA
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	with the sa or 28a	i Direc	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15 Liherty Place apt. #5 21244 U. S. A.
9	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland automent of Health and Mental Hyglene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be nuitied at injury or other traumatic event, the Medical Examiner must be nuitied at e.g.	Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes 2 No 1 No 2 No 2 No 2 No 2 No 2 No 2 No 2 No
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Maryland	should be fill and Mental H marked oth	To Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Atlanta Coleman
	1 and 2 sho Health and om 27 is ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/244 Brenda Granlington 15 Liberty Place Opt. #5 Woodlawn MO
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition 1 Parial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetary or other place) 1 Parial 2 Cremation 3 Removal from State 1 Constitution 5 Other (Specify) 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State
Balt	permit. Departn Imports any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 2/40 North Fulton Avenue. MD 2/2/1 Joseph H. Brown, Jr. Funeral Home Baltimore.
	Pnysician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) a
760,	le be executed vsician and e purial-transit	cal Examiner	Sequentially list conditions. Tary, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last b. Jue to (or as a consequence of): Due to (or as a consequence of):
.O. Box 687	eath certifica attending phy for use as th	Physician/Medic	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ZNo 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 2 Month Day Year 4 Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant at time of death 5 Other (specify) Month Day Year 4 Month Day Year
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Records,	The law requir te has been si age 2 should l	Completed	24a. Was an autopsy findings available prior to completion of cause of death? 1 \(\text{Yes} \) 2 \(\text{No} \) No 1 \(\text{Yes} \) 2 \(\text{No} \) No
of Vital	Physician: The this certificate al director, pag	To Be C	25. Was case referred to medical examiner? 1
Division o	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	27. Manne of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Yes 2 PNo 28d. Describe how injury occurred 1 Yes 2 PNo
DIVI	To the Hospital or Attend within 24 hours after deatl To the Funeral Director: completely filled in by the		3 Suicide 4 Homicide 4 Homicide 28e. Place of Injury - At home, farm, street, fact ry, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospita within 24 hours To the Funeral completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	7 × 1 8		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 13, 2005
	1		September 13, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 600 Liberty Load Randallstown, Maryland 21133 31. Date filed (Month, Day, Year) SEP 1 4 2005 32. Reofrar's Signature SEP 1 4 2005
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 4 2005 32. Regerrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2005 29863 1- State Registrar Amend Item 24a,29c,30 per Dr. Ger GRA 09/14/05dhb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Teresa Smith August 26 2005 2:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 ☐ M 2 🛱 F Yrs. Director 217-86-9911 May 15, 1961 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral', or itema 23a or 28e-f shov Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo MD Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7611 Main Street 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Peges 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ Specify: white 3 Widowed 4 Divorced "natural" Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 house cleaning private homes 7 is marked other traumatic event, 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Joseph Bryan Ann Louise Bonnie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 Department of Health a Important: If Item 27 is eny injury or other trat QDGS. Ann Bryan/mother 7611 Main Street Sykesville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Sign ture of Euneral Service Consee Wade, Dipoctor State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** alienil /Medical Examiner Elestreet ve lung disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the s should be deteched 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ode kins 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate X No 1 Yes 1 Yes 2 No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: ဥ 1 Inpatient 2 PER/Outpatient 3□ DOA this : After thi 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification; 28d. Describe how injury occurred 5 Pending Injury death. 1 Yes 2 No investigation I Director: / 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 6 within 24 hours a To the Funarel I 12 Certifying Physician: To the best of my knowledge, death updated at the time, date and stare, and due to the nauso(s) and mariner as stated. 29a. Certifier Medicai (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) **August 26, 2005** 29b. Signature and title of certifier 29c. License number MDD0054636 Name and address of per n who completed cause of death (Item 23a) (Type, Print) Syed Haque, M.D., 700 Montclaire Ave., Frederick, MD 21701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 1 4 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item/24a, perverbal, G847, 9/14/05 TT

State of Maryland / Department of Health and Mental Hygienes as a

		•	For Stata Registrar		State of Ma		epartment of F Sertificate of			giene 0	05	29864
			1. Decedent's Name	(First, Middle, Las	st)				2. Date of De.		Year	3. Time of Death
	Physicia /Medic		Kathleen	Slezas	;				July		2005	12:34a ^M
	Examin		4a. Facility Name (If	not institution, giv	e street and number)		4b. City, Town, o	or Location of Deat	h	4c. Count	ty of Death	
					linlass D	r.	Middle			Balt	imore	
	Funeral		5. Social Security Nu		ex 7. Ag □M 2XTF	e (In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da	th y, Year)	9. Birthpi Coun	lace (State or Foreign
	Director		212-20-6	213	U.W. 2431	8 5 ^{Yr}	S.		(Month, Da	1-19	VA	-
	and w		Usual Residence of I	10b. County		10c. City, Town o	r Location				1	Od. Inside City Limits
	f sho	ō	MD			Baltim	oro					Y⊒Yes 2 No
	288-	Director	10e. Street and Num	nber		Dartin	10f. Zip Code			10g. Citizen of	What Coun	ntry?
	3a or	Ī	7837 E.	Baltimo	ore St.		2122	Δ		USA		
	death ms 2	Funerai	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decedent of H		Specify Yes or No		ce - Americ	
21215-0036	thin 72 hours after death with the Maryland e. an "natural", or items 23a or 28a-f show Medical Examiner must be notified at	by	1 ☐ Never Marrie		1 ☐ Yes 2 ☐X If Yes, Give Year or Dates:	No	1 ☐ Yes 2 No		to Hican, etc.)	1	ack, White, o ifyWhit	
2-0	27 e H	ted	/Specii	15. Decedent's E	ducation	16a. D	ecedent's Usual Occup	pation	rkina	16b. Kind of	Business/Inc	dustry
2	within lene. than "t	Completed	Elementary/Secon		College (1-4or	o+)	give kind of work done to DO NOT use retire	d)	9			
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Ē	ed is a S	Be	17. Father's Name (-			_	me (First, Middle,	, Maiden Suma	.me)	
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Maryland	12 sho h and is mu	1 6	19a. informant's Na	. ,	Type, Print)		lailing Address (Street					
	s 1 and 2 should if Heelth and Men item 27 is marke other traumatic		Judy Siz				37 E. Bal		St. Ba	20c. Location		
Baltimore,	ages or or o		1 XBurial 2	Cremation 3	Removal from State		isposition (Name of crematory or other pla	1 .	4 0.5		2000	
量	permit. Pag Department Important: any injury o		* 4 ☐ Donation 21. Signature of Fur	5 Other (Special		Oakla	wn Cemete		1-05	Dunda.	Lk,MD	
Ba	permit. Pages Department of th important: if ite any injury or of			10.10	w/////	misk	22. Name and Address 2007 East					
	18		23a. Part1. Enter th	ne disease, or co	ications that caused	the death to no					2123	Approximate
	Dhuaisian		shock, or hear Immediate Cause (I		cations that caused one cause on each li	NENT	ia					Interval Between Onset and Death
7	Physician /Medical		disease or condition resulting in death)		a	a consequence of					-	
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ó	an ar		resulting in death) L	ast	Due to (or as	a consequence of	:					
68760,	tificate be executed g physician and as the burial-transit	edicai		•	d							
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Вох	that the death cert ed by the attending detached for use a	Physician/M	23b. Was decedent in the past 12			2 Fetal death	3 Ectopic pregnand	ey .			ate of delive	Day Year
	the a	sic	1 ☐ Yes 2 ☐ 9 ☐ Unknown		4∏Pregnant a 9∏Unknown	t time of death	5 Other (specify)					
P.0	that the od by detac			icant conditions	contributing to death t	out not resulting in t	he underlying cause of	ven in Part I	23e. Did t	obacco use co	ntribute to th	ne cause of death?
Records,	signe d be	Completed by		LNUTRI		3	g.			Yes 2□No		pably 4 ∐Unknown
Ö	w requir been si should	ete			•				04- 146-		14/	
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a		_	05.146						1 Tes			2 No
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on	iding I th. : After s funer	tio	1 Accident	5 Pending investigation	(Month, Da	ı <i>y Year)</i> Inj		ork?]Yes 2∐No				
Division	Attending in death.	Hica	3 Suicide	6 Could not to	286. Place of in	jury - At home, fam	n, street, factory, office				nber or Rura	al Route Number,
Ö	al or s efte	Certification:	4 🗆 Homicide		building, e	tc. (Specify)		4	City or To	wn, State)		
	To the Hospital or Attending Phwithin 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral	Medical (29a. Certifier (Check only one)	Certifying P	hysician: To the best miner: On the basis of and manner s	of examination and	death occurred at the to or investigation, in my	ime, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) and r date and place	nanner as si e, and due to	tated. o the cause(s)
	To th withii To th comp	×	29b. Signature and	title of certifier	Λ		29c. Licen	se number		29d. Date sign	ned (Month,	Day, Year)
			1 hw	hollete	nl	WID	Do	060560	0	JULY :	29,	2005
				ess person who	pleted cause of	death (Item 23a) (T	ype, Print)			•		
			PANKAI	5 KHE	TERPAL	201-1	09 BAC	K RIVE	R NEC	K RI	D, BA	HITIMORE
		ate	31. Date filed (Mon	th, Day, Year)	pleted cause of TETPAL 32. Regige 4 2005	7ar's Signature	brooks					,
	Re <u>g</u> ist	rar		OEL T	# TOAD	Comes de	1					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 200529865 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2:58 P M September 11,2005 Stringham Bertha V. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, **Examiner** Anne Arundel 2412 Chestnut Terrace Ct. #303 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. And Months Days Hours Min. (Month, Day, Year Aug. 16, 1 Odenton Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 🕱 F New York 1910 Director 058-12-6508 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be mutified at 1 XYes 2 No Director Maryland Anne Arundel Odenton 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? With 2412 Chestnut Terrace Ct. #303 United States 21113 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by Specify: 3 ☐Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Hospital Registered Nurse 4yr 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be (Unknown) Pratt Lucy ပ Lester 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health itam 27 2412 Chestnut Terrace Ct. #303 Odenton, MD 21113 othar t Judy Stringham/ daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ō = ō 1 ☐ Burial 2 XCremation 3 ☐ Removal from State ortant: I * 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crematory 9/14/2005 Odenton, Maryland permit.
Deportm
Imports
any inju 21. Sign to re of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A Momas uanua U M00957 1411 Annapolis Road Odenton, Maryland 21113 23a. Part inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician days Subarachoid Hemorrhage ICD9-430 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 3 cays Headache Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed nding physician and use as the burial-transit 28 days Fall that initiated events resulting in death) Last Due to (or as a consequence of): 68760. Physician/Medical Box IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atter for u 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. ed by the a 1 ☐ Yes 2X No 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed?
1 Yes 2 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ☑ No certificate Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 XYes 2 No ို this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After 1 Natural 5 Pending 1 ☐ Yes 2 ☐XNo death. within 24 hours after death.

To the Funaral Director: A completely filled in by the fu investigation Aug 19, 2005 INK M 1 Case. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) fell going to the bathroom 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2 Accident 3 Suicide 6 Could not be determined 4 Thomicide UNK Budget Inn To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number schulles D0018480 September 14, 2005 mull (30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Ronald Sroka
31. Date filed (Morg Pp. 1ea/4 2005 1684 Village Green, Crofton, Maryland 32. gistrar's Signature State Registrar

			1 - State Amend I Registrar			of Mary H.G847	land / Depa 7,9/14/0	tificate	of He	ealth an <i>eath</i>				005	29866
	Physicia	an	Decedent's Name (First	, Middle, Las	st)						2	. Date of Death Month	Day	Year	3. Time of Death
	/Medic		IRENE_L.					1				SEPT.		2005	7:15A M
	Examin	er	4a. Facility Name (If not in 1559 Breh		e street and ni	imber)				ocation of C ster	Death			inty of Death	
10	Funeral Director		5. Social Security Number 566-20-7765	1	ех □м җ туг	7. Age (In 84	yrs. last birthday) Yrs.		Year Days	If Under 24 Hours	Hrs. 8 Min.	Date of Birth (Month, Day) Une 17,	1921	Cou	place (State or Foreign ntry) LNN .
	and		Usual Residence of Deceded 10a. State 10b.	County		100	c. City, Town or Lo	ocation							10d. Inside City Limits
	Maryl f sho	ro	Maryland Ca	rroll			Wes	stmins	ter						1 ☐ Yes 2√2No
	be filed within 72 hours after death with the Maryland hat Hygiene. od other than "naturel", or Items 23s or 28e-f show event, the Medical Examinat must be notified at	Funeral Director	10e. Street and Number 1559 Brehm R	d.				10f. Zip C	ode	2115	7	10	g. Citizen	of What Cou	ntry?
"	fter deat	Funer	11. Marital Status 1 ☐ Never Married 2	☐ Married	12. Was Dec Armed F 1Yes			Was Deceder If Yes, specify	nt of His y Cuban	panic Origin , Mexican, P	n? (Speci Puerto Ri	fy Yes or No- can, etc.)		Race - Ameri Black, White,	
21215-0036	hours a	by	¥☐ Widowed 4 ☐ D	ivorced ecedent's E	Year or I	oates:		1 ☐ Yes XI		Specify:		1		ecity: W	nite
215	thin 72 e. an "ne Medis	Completed		y highest gra	ide completed	(1-4or 5+)	(Give	kind of work DO NOT use	done du	ining most of	f working		ob. ruid (7 20011100011	oddi y
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Maryland	2 should be filed withir and Mental Hygiene. Is marked other than eumetic event, Ite M.	To Be	17. Father's Name (First, Ferinand Sch	Middle, Last, Wam		NAND S	SCHWAM					First, Middle, M ay Gant		name)	
	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 is marked any injury or other treumetic enones.		19a. Informant's Name/Ro Mary Plunker	, ,								Route Number, ter, Md	,		Code)
Baltimore,	ages 1 a int of Hea t: If Item y or othe		20a. Method of Disposition X Burial 2 □ Crer 4 □ Donation 5 □ C	nation 3		State	Ob. Place of Dispo cemetery, cre	matory or other	er place	ı	Dat			on - City or T	
Baltir	permit. P Departme Importen any injur: once.		21. Signature of Funeral S	Service Lice	nsee	/	Parkwood 23	2. Name and	Address	of Facility	9~20 Lass	ahn Fun	eral	nore, i	
8			23a. Part1. Enter the disc	(//	sech	caused the	death. Do not en			· · · · · · · · · · · · · · · · · · ·		ltimore		21236	Approximate
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	/Medical Examiner		resulting in death)		Due to	(or as a co	nsequence of):			8 2 4	D(A =	4.5			· · ·
	p #	iner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	s.			Cleacke	Courting	cucji	GUC)	المرادات	L.C.			
, o	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last		c Due to	(or as a co	nsequence of):						· · · · ·		
68760,	icate be physicia s the bu	edicai		(_ d										
Вох	that the death certificate be executed od by the attending physician and detached for use as the burial-transit	Physician/Me	1F FEMALE: 23b. Was decedent pregr in the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			birth 2 🗍 nant at time	Fetal death 3	⊒Ectopic preg ☐ Other (spec					23d.	Date of deliv Month	ery Day Year
ds, P.O.	gn gn	by	Part II. Dther significant	conditions	contributing to	death but no	t resulting in the u	nderlying cau	ise giver	n in Part I.				_	he cause of death?
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	yelcien: is certific director,	To Be	25. Was case referred to examiner? 1 ☐ Yes 2 ☑ No	medical	Hospital:	Inpatient	2 ☐ ER/Outpatie	nt 3□ DOA				Check on one	_	Other (Sees)	6.1
on of	ing Ph h. After th funeral		27. Manner of Death	Pending investigatio	28a. Date (Mo		28b. Time o	_	Work?	at es 2 No	28	d. Describe ho			y)
Division	or Attendi after death. Director: A in by the fu	Certification:		Could not be determined	e 28e. Plac	e of Injury - ling, etc. (S	At home, farm, st pecify)	reet, factory, o	office		28	f. Location (Str City or Town,		umber or Run	al Route Number,
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical Co	29a. Certifier 12 ((Check only 2 1	Certifying Pl Medical Exa	miner: On the	e best of my basis of exa nner stated.	y knowledge, deat mination and/or in	h occurred at vestigation, in	the time	, date and p	place, and	d due to the ca at the time, da	use(s) and te and pla	d manner as s	stated. o the cause(s)
	ro the vithin o the omple	Mec	29b. Signature and title o	f certifier	und ma	stated.		29c. l	License	number		29	d. Date si	gned (Month,	Day, Year)
	F>F0		1 GiA	17	y C	じ		1):	250	62			9.7	-2005	
	15		30. Name and address of					Print)			3764	A, NVS	211	36.	
	Sta	te	31. Date filed (Month, Da	y, Year)	\$ 2.	Registrar's			1 /			,			
	Regist		2FL T	4 200	S ALRE	and I	Signature	and the same							

	4	For State Registrar	State of Mar	yland	l / Depa	artment of t	lealth and		giene2	005	29867
Physicia /Medica	n	1. Decedent's Name (First, Middle, Last) Miriam Loretta	Sheldon					2. Date of De. Month Septemb	Day	Year 2005	3. Time of Death 8:00 A M
Examine		4a. Facility Name (If not institution, give s Gilchrist Center	treet and number)			4b. City, Town, C	or Location of De	ath		unty of Death altimor	e
Funeral Director		5. Social Security Number 6. Sex 217-14-0188		(In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days		n. (Month, Da	th y, Year) 1924	9. Birthpli Count Mary	ace (State or Foreign ry) Land
ehow		Usual Residence of Decedent 10a. State 10b. County Manufland Pall timeste		10c. City,	, Town or Lo					10	ld. Inside City Limits 1 ☐ Yes 2 No
death with the Maryland me 23a or 28a-f ehow	Direct	Maryland Baltimore 10e. Street and Number		,	NO	101. Zip Code	102/			of What Count	ry?
ē = 1	Funeral Director	3800 Meghan Drive 11. Marital Status 1 Never Married 2 Married	2. Was Decedent Ev Armed Forcas? 1 Yes 2 No	ver in U.S				(Specify Yes or No erto Rican, etc.)		Race - America Black, White, e	tc.
Maryland 21215-0036 at 2 should be filed within 72 hours after lith and Mental Hygiene. 77 is marked other then "naturel", or Ite reumatic event, the Modical Examples.	Completed by	3 X Widowed 4 □ Divorced 15. Decedent's Educ (Specify only highest grade	Year or Dates:		16a. Dece	dent's Usual Occu kind of work done DO NOT use retire	pation	vorking		of Business/Ind	
Faryland 2121 2 should be filed within and Mental Hygiens is marked other then eumatic event, the Men	Comp	Elementary/Secondary (0-12) 12th Grade 17. Father's Name (First, Middle, Last)	College (1-4or 5+)		unting C	lerk	lame (First, Middle,		ture Co	mpany
yland	To Be	Frederick Pra			40h Mailie	Add Care	Rose	Weid	inger		0.41
ore, Mar ss 1 and 2 sh of Health and litem 27 is n r other treun		Barry C. Sheldon	(son)	lan D	4345	Hallfie	ld Manor	Rural Route Number Drive, 1	Vottin	gham, M	D 21236
Baltimore, permit. Peges 1 ar Department of Hea mportant: If liem not injury or othe page.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		idens		Cem. 9/	14/2005	Balti		aryland
Baltimol permit. Peges Department of Important: If It eny injury or one		21. Signature of Funeral Service License Buch a Wil			22	2. Name and Addr 9705 Bel	ess of Facility S air Rd.,	chimunek Baltimo	Funer re, MD	al Home 21236	S
Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused to cause on each line	Э.			ing, such as card	liac or respiratory a	rrest,		Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a								
be executed iclen end burial-transit	Examiner	Sequentially list conditions, if any, loading to immodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a								
76(cal	L.	i.								
Vision of Vital Records, P.O. Box 68 Attending Physicien: The law requires thet the death certificat cadeath. actor and ther this cartificate has been signed by the attending phy by the funeral director, paga 2 should be datached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	Fetal	death 3[Ectopic pregnand Other (specify)	су		23d	Date of delive Month	ry Day Year
Cords, P. (wrequires that the been signed by should be datace	ed by Ph	Part II. Other significant conditions con Chronic Lena	Z\		ulting in the u	nderlying cause g	ven in Part I.				e cause of death?
Vital Records, sicien: The law requires II cartificate has been signe rector, paga 2 should be contributed.	Completed							24a. Was auto perfo 1 Yes	psy ormęd?	4b. Were autop prior to con death? 1 \(\sum Yes\)	psy findings available apletion of cause of
of Vital F Physicien: Th r this cartificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital:	nt 2 🗆 i	ER/Outpatie	nt 3 DOA		Death <i>Check only</i> of Grant Gr		Other (Specify	Hospice
Division of or Attending Physafler death. Director: Attenthis in by the funeral d	Certification: 1	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day	Year)	28b. Time o Injury	f 28c. Inju W M 1[ury at ork?] Yes 2 □ No	28d. Describe	how injury or	ccurred	
Divisio To the Hospitel or Attandi within 24 Hours after death. To the Funerel Director: A completely filled in by the fo	Certifle	4 Homicide determined	28e. Place of Inju building, etc.	." (Specify	′)			City or To	wn, State)		Route Number,
Div To the Hospitel or within 24 hours afta To the Funerel Div completely filled in	Medical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best of ner: On the basis of and manner stat	examinat	wledge deat tion and/or in	h occurred at the ovestigation, in my	ima date and plo opinion, death or	ace, and due to the courred at the time,	date and pla	d mannar as st ace, and due to	the cause(s)
To the transfer of the transfe	Σ	29b. Signature and title of certifier	1-1-1	41			61199			igned (Month, L	
10		30. Name and address of person who co	ompleted cause of de			-		Touson		21204	
Sta Registr		31. Date filed (Month, Day, Year) SEP 1 4 20	32. Degistra			aut o				(

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Sheldon, Miriem

State of Maryland / Department of Health and Mental Hygiene 20051 - For State Registrar 29868 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** May Elizabeth Sloffer September 9, 1:45 A 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Fairfield Nursing Center Crownsville Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 918 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 217 F 212-12-0910 86 Director Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Items 23e or 28a-f show the Medical Examiner must be notified at Ocean City 1 Yes 2 No Director Maryland Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 112th Street. Unit 1270 21842 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e any injury or other traumatic event, the Medical Examinations. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2X No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Butcher's Assistant 9th Grade Butcher Market 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Korber Guy Edward Sloffer Elizabeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David McKeldin (great-nephew) 241 Old Line Avenue, Laurel, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State Druid Ridge Cemetery 9/10/2005 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated ascents.) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Month 4☐Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 14 No 24a. Was an autopsy performed? (es 2) 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funerel Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: or Attending 1 Salatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of of 29c. License number 29d. Date signed (Month, Day, Year) MAD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Olin Busnie MD 21061 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death STENGLE **Physician** STHER September 8, 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFOR HERI TAGE TREE 7 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours 214-16-1992 Director 84 April 1921 1, Maryland Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location Itams 23a or 28e-f show ref must be notified at 10d. Inside City Limits Harford Edgewood 1 ☐ Yes 2 No Directo Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 904G Cedar Crest Court 21154 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 21 No treumatic event, the Medical Exami 1 ☐ Yes 2 ☐ No Specify: þ Year or Dates: white 3⊈ Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coflege (1-4or 5+) Bendix Corporation s 1 end 2 should be filed w f Health and Mental Hygier Item 27 Is marked other th chemist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Scheck Anne Esther McMenamy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara A. Stengle 711 Pinefield Way, Edgewood, Md. 21040 If Item 27 permit. Pages 1 end Department of Health Important: If Item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 9/12/2005 * 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Finat disease or condition resulting in death) Dente My OCAMPIAL INFACTION **Physician** SAMEDO /Medical Due to (or as a consequence of): **Examiner** LARS Hyperkension Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner physicien and s the burial-transit DIBBetes 10 Ans that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical 98 IE EEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown detached 9□ Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 200 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director. 15515Hed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: CARL 1 Inpatient ٩ 1 Tes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 13. Natural 2 Accident 1-1266/4 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel 24 hours 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier within 24 ho To the Fun completely f (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 35889 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 615 W. MACPHAIL, Bul por MA 21014 SPANIS SLERKO 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State Registrar DHMH 17 Rev 1/2001

3altimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 9, **Physician** James Astor Sampson 5:20 P M September 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Dundalk Baltimore 3517 Sollers Point Road 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Days Hours 1 □XM 2 □ F Yrs. Director 412-20-1974 85 May 13,1920 North Carolina Usual Residence of Decedent with the Maryland 10a, State 10c. City. Town or Location 10b. County item 27 is marked other than "natural", or iteme 23a or 28e-1 show other treumatic event, the Madical Examinar must be motified at 10d. Inside City Limits Director 1 ☐ Yes 2 X No Dundalk Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3517 Sollers Point Road 21222 United States deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? ACXYes 2☐No If Yes, Give Year or Dates: 1942-45 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Depertment of Health and Mental Hygiene. I important: If Item 27 is merked other than "natural", or Item any injury or other treumatic event, the Medical Examinations. 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Š Specify: 3 Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Spray Painter General Motors Corp. Year 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Orland Sampson Minnie Lee Bryant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frieda C. Minner (Daughter) 3518 Louth Road Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gdns. 9/14/2005 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ignature of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoet or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician esta disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Nown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1□ Yes 2☑No 1 TYes To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Desidence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending efter death. 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours e To the Funerel (Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7021274 0 20 31. Date filed (Month, Day, Year) 32. Apegistrar's Signature State 14 2005 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 0514 September Year **Physician** Lynette Virginia Sykes 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Boltimore Jinzi Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb 14, 19 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F West Virginia Yrs 1922 Director 233-30-5649 83 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Completed by Funeral Director Reisterstown Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 21136 106 Danbury Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married ☐Yes 2 No Yes, Give 1 ☐ Yes 2 ☑ No Specify: Specify: White ff Yes, Give Year or Dates: 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Florist Shop Bookkeeper 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be fill ment of Health and Mental H lant: If Item 27 is marked of Erma May Smith Phares Sherd permit. Pages 1 and 2 shoul Department of Health and Me Important: If Item 27 is markeny injury or other traumationse. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sister Ruth Bernstein Lutherville, MD 26 Barthel Court 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 9/16/05 Pikesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 11824 Reisterstown Road Inkens ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Phermonis **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and Il-transit Due to (or as a consequence of): physician a s the burial-Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 A No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? á Rush Disease 2 No 3 Probably 4 Unknown Completed page 2 should peeu ronny Artery Disease 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No has ormed? this certificate 1 Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3[] DOA ပ 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation in by the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide completely filled 29a. Certifier 🗷 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year) 33 Registrar

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2005

21215-0036

and

more.

P.O.

Division of Vital Records,

2901

32 Registrar's Signature

West Belvedere Ave.

State of Maryland / Department of Health and Mental Hygien 2005 29872 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** LUCILLE MARIE KROYER SCHUSLER September 10, 20 2005 12:48Å /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6604 Walnutwood Road Baltimore County Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🛱 F Director 141-03-1159 Feb 17, 1915 New Jersey Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits rai", or iteme 23a or 28a-f ehow Examiner must be nutified at 1 ☐ Yes 2 📉 No Director Maryland | Baltimore County <u>Baltimore</u> 10f. Zip Code 10g. Citizen of What Country? 21212 6604 Walnutwood Road USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
nt: If Item 27 is marked other than "natural", or iten any or other traumatic event, ins Maulical Examinating or other traumatic event, ins Maulical Examination. ☐Yes 2X No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ White 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Board of Education Secretary 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Kroyer Augustina Pasqualino Pivano 2 Arthur 19a. Informant's Name/Relationship (Type, Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6604 Walnutwood Road, Baltimore, Maryland 21212 of Disposition (Name of Date 20c. Location - City or Town, State Jeanne Schusler Ten Broeck 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
eny Injury or oti 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Cemetery 9/13/2005 Baltimore, Maryland 21. Signature of Furnanti Sarvice Licensee Mitchell-Wiedereld runeral none, 4500 York Road, Baltimore, Maryland 21212
Approximate Interval Between Onset and Death Mitchell-Wiedefeld Funeral Home, Inc. Martin D. Lawson 23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** myocode /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the deeth certificate be executed and physicien are the burial-t Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 2 No 1 ☐ Yes the Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient ည 2 ER/Outpatient 3□ DOA this. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2411 W. Belvedere Avenue, Baltimore, Maryland 21214 Gwen Dubois, M.D. 2005 Alexandra Signature 31. Date filed (Month, Day, Year) 1 4 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygier 15

			1 - For State Registrer	State of Man	yland / [Depar Cert	rtment ificate	of He	ealth ar eath	nd Me		gier		29873
	Physici /Medic		Decedent's Name (First, Middle, Last) MIRIAM			SĀ	CHS				2. Date of De Month SEPTEMI	Da	12, 200	3. Time of Death 55 4:30 A M
	Examin		4a. Facility Name (If not institution, give st CHARLESTOWN RETIR		ΓER		4b. City, To		ocation of I		LE.		c. County of De	
	Funeral Director			7. Age (I	n yrs. last bir 85	rthday) Yrs.	If Under 1 Months	Year Days	Hours	Min.	B. Date of Bir (Month, Da NUG. 12	th 19, Year 192	9. 8	irthplace (State or Foreign Country) MD
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MD BALTI		Oc. City, Tow		ation SVILL	F						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the 3a or 28a 1 be noti	I Director	10e. Street and Number 713 MAIDEN CHOICE				10f. Zip C	ode	21228)		10g. Ci	itizen of What	
036	within 72 hours after death with the Maryland one. Then "natural", or ttems 23a or 28a-f show he Medical Examinar must be notified at	by Funeral		2. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:			as Deceder Yes, specif	nt of Hisp y Cuban,			ify Yes or No ican, etc.))-	14. Race - An Black, Wi Specify:	USA nerican Indian, nite, etc. WHITE
9500-91212	d within 72 ho giene. rr then "natur rre Medical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) Coltege (1-4or 5+)		(Give ki	O NOT use	done du	on ring most o	of working	9	16b. K	Cind of Busines	s/Industry
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	t and Health em 27 ther t		BEATRICE JENNY KIR	ATLI/GREAT	NIECI 20b. Ptace o	E 40	036 0 tion (Name	RME of			PALO A	ALTO	, CA 94	1306
Baltimore,	Page ment o ent: If ury or		1 Burial 2 X Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Fundal Service Conse		HILLT	OP S		E CO					OWSON,	
ñ	permit. Depart Import any inj		23a. Part1. Enter the disease or complic shock, or heart failure List only one	ations that caused the	e death. Do	89	00 RE	ISTE	RSTOW	IN RC)AD - I	PIKE	& BROS. SVILLE	Approximate Interval Between
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O. Box	death cert e attendin ed for use a	Physician/M	tF FEMALE: 23 b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death		ctopic preg Other (spec						23d. Date of d Month	etivery Day Year
rds, P	ires tha signed d be de	b	Part II. Other significant conditions cont	ributing to death but n	not resulting in	in the und	lerlying cau	se given	in Part I.			obacco Yes 2	_	to the cause of death? Probably 4 Unknown
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	rsician: Th s certificate director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 27No	ospital:	2 □ EB/Oı	utnationt	3□ DOA	Other:			Check only o		6 ☐Other (Sp	anife!
Division of	Attending Physician: If death. ector: After this certific by the funeral director,	ation: T	27. Manner of Death 1/☑Naturat 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Ye	28b.	Time of Injury		: Injury a Work? 1 🗆 Ye		28	ld. Describe I			o city)
DIVIS	P in it	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, fa Specify)	arm, stree	et, factory, o	office		28	If. Location (S City or Tox	Street ar wn, State	nd Number or I a)	Rural Route Number,
	To the Hospitel or within 24 hours afte To the Funeral Dir completely filled in	Medical	(Check only Z Medical Examin	cien: To the best of n er: On the basis of ex and manner stated	amination an	e, death o	stigation, ir	the time, my opin	nion, death	piace, an occurred	at the time,	date and	d place, and di	ue to the cause(s)
1			29b. Signature and title of certifier	un s	W					4	0	290. Da	The signed (Mo)	oth, Day, Year)
2			30. Name and address of person who con	npleted cause of deat	h (Item 23a)	(Type, P	Cly	a	mer	u	Con	ce	Call	unalle M

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Registrar

State of Maryland / Department of Health and Mental Hygiene O or

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Physici	an	Decedent's Name (First, Middle, L Mary Brown Thom	•				2. Date of Dea Septemb		2 <i>0</i> 65	3. Time of Death 10:04 ам
/Medic		4a. Facility Name (If not institution, g			4b. City. Town, o	r Location of Death	J	4c. County		10.04 am
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ineral rector				rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) Dec. 30	Year)	9. Birthp Cour	place (State or Foreign htty) Land
rnan natural, or nems 23a or 28a1 snow the Medical Examiner must be notified at	}	10a. State 10b. County	10c. (City, Town or Lo	cation			·	1	0d. Inside City Limits
Tell le	ctor	Md. Harf	ord B	Bel Air					j	1 ☐ Yes 2 ➡ No
	Dire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of	What Cour	ntry?
	ral	2204 Candices C	noice Court 12. Was Decedent Ever in	110	210			U.S.A		
	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2√2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		ck, White,	ean Indian, etc. hite
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	e Co	12 years 17. Father's Name (First, Middle, Lat	st)		-	18. Mother's Nam				
	OB	James W. Brown				Elma Kn	ockel			
	_	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	g Address (Street	and Number or Rui	ral Route Number	, City or Town,	State, Zip	Code)
		Stanley Clark/s				s Choice	Court, E	Bel Air	, Md.	21015
Ì		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	□Removal from State	. Place of Dispo cemetery, cres	sition (Name of natory or other place	ce)	Date	20c. Location	City or To	wn, State
		` 4 ☐ Donation 5 ☐ Other (Spec	Ba Ba		rematory	9/8/	05	Baltimo	ore,	Md.
		21. Signature of Funeral Service Lic	ensee	S	. Name and Addre chimunek	ss of Facility Funeral	Home of	Bel Ai	c, In	с.
		23a. Fart1. Enter the disease, or co	as leations that caused the de						-	
		shock, or heart failure. List on	y one cause on each line.	aun. Do not em	er the mode or dyin	g, such as cardiac	or respiratory arri	est,		Approximate Interval Between Onset and Death
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	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)				te of delive nth	Day Year
	by PI	Part II. Other significant conditions	contributing to death but not r	esulting in the u	nderlying cause give	en in Part I.	23e. Did tot	pacco use cont	ribute to th	ne cause of death?
	ed						1 □ Ye	s 2 No	3 Prob	abiy 4 Denknown
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	<u>1</u>	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury	☐ ER/Outpatier						Assisted Livil
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	edlcal (29a. Certifier 1 Certifying I (Check only one) 1 Medical Ex	Physician: To the best of my keminer: On the basis of examinand manner stated.	nowledge, death nation and/or in	n occurred at the time restigation, in my of	ne, date and place, pinion, death occur	and due to the cared at the time, da	ause(s) and ma ate and place,	nner as st and due to	ated. the cause(s)
	Ň	29b. Signature and title of certifier	101100		29c. License			9d. Date signe		
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)		30. Name and address of person wh	completed cause of death (it	tem 23a) (Type,	Print) (1 1 =	aluF	REI A	= 10 nn	an s	7, 2005 LAND 21014
	te.	31. Date filed (Month, Day, Year)	32. Redistrar's Sig	nature	IT /IVCI	1000	100 14.	LKIN	11-76	JINA 21019
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State of Maryland / Department of Health and Mental Hygiene 2005 29875 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** So Ming Tong SEPTEMBER 8, 2005 10:30A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year II Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months 1 □ M 2 X F 141-26-6419 88 China 17, Director Feb. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits liem 27 ie marked other then "naturel", or Items 23a or 28a-f ehow other traumatic event, the Madical Examiner mast be notified at 1 ☐ Yes 2 X No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27 Neves Court 21234 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filled within 72 hours after n and Mental Hygiene. ☐Yes 2XNo fYes, Give 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: Asian lf Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clothing 5th Grade Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Chen Fong Chung (surname unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 te m any injury or other traum once. Mr. Fair Tong (son) 27 Neves Court, Baltimore, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Garrison Forest VA 9/14/2005 Owings Mills. MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician a DISSIMINATED INTRAVASCULAR COAGULATION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CARCINOMA OF THE PANCREAS MUNTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine been signed by the attending physicien and should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760; Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
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State of Maryland / Department of Health and Mental Hygien 2005 29876 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SEPT. 1², 200⁵ ROBERT HERBERT THOMAS 8:30 av /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1351 S. CLINTON STREET APT. 202 BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 193 2 MARYLAND 6. Sex 9. Birthplace (State or Foreign **Funeral** Days 1**X** M 2 ☐ F 219-28-0601 73 Director Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f shov Director 1 XYes 2 No MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1351 S. CLINTON STREET APT. 202 21224 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
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LILLY & ZEILER INC. FUNERAL HOME
700 S. CONKLING STREET, BALTO., MD. 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestine Physician ears /Medical Due to (or as a con-Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of): as the burial-Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown the 9☐ Unknown signed by Part II. Other significant conditions, contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has this certificate 1 🗌 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No Certification; To After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number D-16362 9/13/05 physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Balto, MD 2123 31. Date filed (Month, Day, Year) State

Registrar

December 1 Annual Process March		•	For State Registrar	State of M	larylan				ealth a Death	nd Me		-	200	5	2987
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State of Maryland / Department of Health and Mental Hygien 2005 29878 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Hunter Merle Williams 09 11 2005 1:05PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Greater Baltimore Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Months Days Director 197-22-3841 Pennsylvania 08/26/1930 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic avant, the Medical Exactinar must be notified at Director 1 ☐ Yes 2 X No MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 0 itams 23a Completed by Funeral 1204 Cheshire Lane 21014 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 (XYes 2 □ No If Yes, Give Korean Year or Dates: Host Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 🗓 No Specify: 3 ☐ Widowed 4 ☐ Divorced White Host 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Staff Manager Insurance Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked of ပ Merle Trauger Williams Charlotte Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health 1204 Cheshire Lane - Bel Air, Maryland Dora M. Williams (wife) 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department * 4 ☐ Donation 5 ☐ Other (Specify) any injury Highview Mem. Gdns. 09/16/2005 Fallston, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. L a wellens 11750 Belair Road - Kingsville, Maryland 21087 23a. Part1. Enter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Cancer 3 month /Medical Due to (or as a synsequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 Yes 2 No 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of ause of death?

1 Yes 2 No autopsy performed Division of Vital 1 Yes 2 No tha Hospital or Attanding Physician: 25. Was case referred medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ပို 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending s after de. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hou. the Funaral D cai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The destroying Physician: 10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner, styled. (Check only one) tha 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) ٥ 12 30. Name and address of person who completed cause of death (Item 23a) (Type BERGO R45En 32. Registrar's Stenature Registrar

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	Physici /Medic Examir	al	Decedent's Name (First, Middle, Last Name (First, Middle, Last Name (If not institution, give	tzel		4b. City. To	wn, or Location		2. Date of Dea Month 09	09	Year 2005	3. Time of Death 2230 M
*.	Funeral Director	ier	University of Manyla 5. Social Security Muniber 16. S	nd Medica	(In yrs. last bir	thday) If Under 1	Chimare	r 24 Hrs. Min.	B. Date of Birtl (Month, Day Septembe	Balti	imore Ci	ity place (State or Foreign placy) Imone, Many Land
	Maryland France fled at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore		10c. City, Town							0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ath with the s 23e or 28e just be noti	rai Director	10e. Street and Number 1507 Rosewick Avenue			10f. Zip C 21237				10g. Citizen o		
9600	d within 72 hours after death with the Maryland Jiene. I then "neturel", or Items 23e or 28e-f show The Medical Exatta or must be codified at	d by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo	13. Was Deceder If Yes, specify	No Specify		ify Yes or No- ican, etc.)	Spec	WILL	etc.
21215-0036	I within 72 iene. r then "nei in wedic	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4or 5 N A	+)	Decedent's Usual (Give kind of work life. DO NOT use	done during mos	st of working	9		Business/Ind	
Maryland	ed all all	To Be (17. Father's Name (First, Middle, Last) August Kahler 19a. Informant's Name/Relationship (1)	vpe. Print)	19b	. Mailing Address (5	Lydi	a Eden		Maiden Sum	ame)	
	es 1 and 2 of Health a f item 27 ls r other tre		Nancy L. Weitzel 20a. Method of Disposition 1 X Burial 2 Cremation 3 C			1507 Rosewi Disposition (Name y, crematory or other	ck Avenu		timore, M		1 21237	
Baltimore,	permit. Pag Department Importent: I any Injury o once.		4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen	ba Obm	·	Lassahn	Address of Facili Funeral H	tine Inc	2	Baltimor		land
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.O. Box 6	The law requires that the death certificate has been signed by the attending places as should be detached for use as to	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 □Fetal death	3 ☐Ectopic preg 5 ☐ Other (spec					Date of delive Month	ery Day Year
Ω.	w requires that I been signed by should be deta	þ	Part II. Other significent conditions of	ontributing to death bu	t not resulting in	the underlying cause	se given in Part I	l.		bacco use co es 2 □ No		e cause of death?
of Vital Records,		e Completed	25. Was case referred to medical				26 Place	e of Death	The same	sy	prior to con death?	osy findings available npletion of cause of 202 No
Division of Vi	tending Phys leath. tor: After this the funeral di	ertification; To B	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 5 Suicide 6 Could not be		y 28b. T Year) 28b. T	tpatient 3 DOA ime of 28c ijury M m, street, factory, o	Cther: 4 Number	ursing Home 28 (No	9 5 ☐ Reside	ow injury occi	urred	/ Route Number
Div	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edicai Certi	(Check only 2 Medical Exam	building, etc /sicien: To the best of iner: On the basis of	of my knowledge examination and	death occurred at	he time, date ar	nd place an	City or Town	n, State)	ich a	we. md.
)	To the within 2 To the comple	Med	29b. Signature and the of certifier Alka	Philp, MD	lea.	29c. L	icense number			9d. Date sign		
_	15		30. Name and address of person who o	completed cause of de	S. Gre	Type, Print) ene Str	ect	Balt	mure	MD	212	-01
95.	Sta Registi	200	31. Date filed (SEP 4 200	5 Registra	rs Signature	perti						

State of Maryland / Department of Health and Mental Hygien 2005 29880 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEFTEMBER **Physician** -RANCIS (NesTwood 10,2005 7:50 FM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Center Towson Saint Joseph Medical If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours Min 10M 20 F Days 202-03-0905 Director Usual Residence of Decedent the Manyland 10d. Inside City Limits 10a State 10b. Count 10c. City, Town or Location 7 is marked other then "neturel", or Iteme 23e or 28e-f show traumatic event, the Modical Exact) an mark be notified at 1 Yes 2 No Completed by Funeral Director BALTIMORE PARKUILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 end 2 should be filled within 72 hours after death with it.

Department of Heelith and Mental Hyglene.

Important: If Item 27 is marked other then "neturel", or Iteme 23e or 2.

Important: If Item 27 is marked other then "neturel", or Iteme 23e or 2.

PORCE. LACKAWANNA 8.208 U.S.A 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No U.S. If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married U.5 1 □ Yes 2 1 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: WhiTe Widowed 4 □ Divorced ARMY 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1,4or 5+) CORP 12+4 COCA COLA Mechanic NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown UNKNOWN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 917 B. 4 HO. NO Aulelle YARRISK 21221 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State BAYVIEW CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility STELLA Funeral Home CHTD. 21. Six ature of Funeral Service Licensee HARTLEY MILLER - STELLA 7527 harford RD. Bs Ho 23a. Parft. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a CHRONIC OBSTRUCTIVE PULMONARY DISEASE Physician /Medical Due to (or as a consequence of): Examiner EXACERBATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner ettending physicien end for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 🗆 No 3 Probably 4 Unknown Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes Division of Vital Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No patient ٩ 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Natural 2 Accident Injury efter death. 1 ☐Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 25886 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ILIA CEBALLOS. M.D. 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 D. 76.71 (82. Registrar's Signature 31. Date filed (Month, Day, Year) SEP 1 4 2005 Registrar

			for State Registrar	State of Mary		artment of H		Mental Hygien	211115	29881
38	Physici /Medic		1. Decedent's Name (First, Middle, Last)	You	ng			2. Date of Death	2-50 S	3. Time of Death 8.46 P M
	Examin	er	4a. Facility Name (If not institution, give s Sandtown Winchest	er	0	Balto	or Location of Deal		kc. County of Dea	
	- Funeral Director		5. Social Security Number 6. Sep 1 1 2 12-01-2872	7. Age (In	yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min		9. Bin 14	thplace (State or Foreign ountry) Va
	death with the Maryland me 23a or 28a-f ehow fromet be notified at	Director	Md 10b. County N/ 10e. Street and Number	A	Balto	10f. Zip Code			Citizen of What Co	10d. tnside City Limits X☐ Yes 2 ☐ No puntry?
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aitimor	it. Page sriment o srient: if njury or t.		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	amoval from State	Garrison	Forest \(\frac{1}{2}\) Name and Addre	Vet 9-14		ings Mil West	ls, Md
ğ	Deperment of the control of the cont		23a. P. int 1. Enter the disease, or communication of the communication	cations that caused the	death. Do not ent	4300 er the mode of dyir	Wabasi	n Avenue	west Balto, M	d 21215 Approximate Interval Between
8/60,	Physician and whisician and hysician and price price and the price and t	lical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor Due to (or as a cor Due to (or as a cor	Isequence of): Isequence of): Isequence of):	Cordi M	ovoscu	be Dise	2se	Onset and Death
O. Box 6	the death certificate y the attending phys ached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	/		23d. Date of del Month	ivery Day Year
cords, P	w requires that the de been signed by the should be detached	ρ	Part II. Other significant conditions cor	ntributing to death but no	t resulting in the u	nderlying cause giv	en in Part I.		use contribute to	the cause of death?
Ä	The lar	e Completed	25. Was case referred to medicat	·*			00 Diversión	24a. Was an autopsy performed?	prior to death?	atopsy findings available completion of cause of
n or vi	ding Physician: h. After this certific funeral director,	lon: To B	eyaminer?	1 Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatien 28b. Time of Injury	t 3 DOA Oth	er: 4 Nursing F	ath (Check only one) Home 5 Residence 28d. Describe how injugate		cify)
DIVISION	Atten or deat ector; by the	Certificati	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp	At home, farm, str		Yes 2 □ No	28f. Location (Street a City or Town, Sta		ıral Route Number,
	To the Hospitel or within 24 hours afte To the Funaral Dir completely filled in	edical (29a. Certifier 1 Certifying Phys (Check only 2 Medical Examination)	sician: To the best of my ner: On the basis of examination and manner stated.	knowledge, death mination and/or inv	occurred at the ting estigation, in my o	ne, date and place pinion, death occu	e, and due to the cause(urred at the time, date ar	s) and manner as nd place, and due	stated. to the cause(s)
	To t com	Σ	29b. Signature and title of certifier Active Activ	R. N	1 D	29c. Licens			ate signed (Month)	
	2		30. Name and address of person who con LIADAT ALI	mpleted cause of death MD 821	(Item 23a) (Type,	Eytan	st. B	alterre	MD2	1201
	Sta Registr		31. Date filed (Month, Day, Year) \$\ SEP I 4 2	32. Registrar's S	ignature	out				

			For State Registrar	State of Maryland		nt of Health and te of Death	d Mental Hy	giene 2005	29882
	Physici /Medic Examin	an al	1. Decedent's Name (First, Middle, Last, Aa. Facility Name (If not institution, give	street and number)	Her RA	Town, or Location of Do	townill		3. Time of Death 3:55 p M h
	Funeral Director		5. Social Security Number 6. Sec. 2 2 0 14-5962 10 Usual Residence of Decedent	7. Age (In yrs. Ia	st birthday) If Under Months	T 1 Year If Under 24 H Days Hours N	lin. (Month, Da	rth 9. Birth Co 5 - 2 0 Bath	hplace (State or Foreign untry)
	Maryland e-f show	tor	10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	uth with the 23e or 28 unt be not	Funeral Director	10e. Street and Number 901 Barebra	nch Court	10f. Zip	3130£		10g. Citizen of What Co	untry?
036	hours after death with the Maryland tural', or Hems 23e or 28e-f show al Examiner must be multiput at	É	11. Marital Status 1 Never Married 2 Married Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates:	13. Was Dece If Yes, spe	dent of Hispanic Origin? cify Cuban, Mexican, Po 2 No Specify:	(Specify Yes or No leno Rican, etc.)	14. Race - Ame Black, White Specify:	
21215-0036	within 72 ene. then "ne	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Decedent's Usu (Give kind of wo life. DO NOT u	ork done during most of ise retired)	working	16b. Kind of Business/	Industry
Maryland 2	ould be filed Mental Hygi erked other	To Be C	17. Father's Name (First, Middle, Last)	Hunt			H 1/2	, Maiden Sumame)	
	1 an Heal em 2 ther		19a. Informant's Name/Relationship (T) Girand Glyn Your 20a. Method of Disposition	g, Daughter	90\ E	zarebrai	Rural Route Numb	Per, City or Nown, State, 2 Res VIII 20c. Location - City or	Mo
Baltimore,	permit. Pages Department of Importent: if it any injury or o		1 Burial 2 Cremation 3 F 14 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice	Removal from State		evans 9	20-05 Villian	Counce C	ommunity
	Physician /Medical Examiner	iner	23a/ Part 1. Enter the disease, or comply shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Unidentying Cause (Disease or injury	ications that caused the death. ne cause on each line. a	ence of):	de of dying, such as card	diac or respiratory a	irrest,	Approximate Interval Between Onset and Death
8760,	ate be executed hysician and the burial-transit	lical Examiner		Due to (or as a conseque	ance of):				
P.O. Box 6	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rall director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal o 4 ☐ Pregnant at time of dea 9 ☐ Unknown	death 3 □Ectopic pi			23d. Date of deli Month	very D <i>a</i> y Year
	juires that n signed b ild be deta	þ	Part II. Other significant conditions co	-	ting in the underlying o	cause given in Part I.	23e. Did 1	tobacco use contribute to Yes 2 No 3 ☐ Pro	the cause of death?
of Vital Records,	The law require zate has been si page 2 should t	Completed	Diabetes Me	ellitus			24a. Was - auto perfo 1 \(\text{Yes}	san 24b. Were au prior to death? 1 □ Yes	topsy findings available completion of cause of
/ita	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	In mital:		part of the control o	Death (Check only o		
	fune fune	tlon; To	27. Manner of Death 1 ☑Natural 5 ☐ Pending		R/Outpatient 3 DO 28b. Time of Injury	OA Other: 4 Nursin 28c. Injury at Work? 1 Yes 2 No		idence 6 □Other (Spec how injury occurred	city)
Division	or Atten or Atten or deat Director: in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, factor		28f. Location (City or To	Street and Number or Ru wn, State)	ral Route Number,
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medicel Exami	sicien: To the best of my know ner: On the basis of examination and manner stated.	ledge, death occurred on and/or investigation	at the time, date and plan, in my opinion, death of	ace, and due to the courred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	lo th	Me	29b. Signature and title of certifier		296	c. License number		29d. Date signed (Month	n, Day, Year)
	->-0		raren Z.	Balita, M.D.		0005867	6	September	10, 2005
	2		20 Name and address to the same		23a) (Type, Print) MGIN STO	et, suite:	on, Reis	terstown, N	10 21136
	Sta Registi		31. Date filed (Month, Day, Year) SFP 1 4 2005	a2. Registrar's Signatu	ire /				

		•	For State Registrar	State of Mar	-	partment of l ertificate of			giene Reg. No. 2	005	29883	
	Physici /Medic	an	Decedent's Name (First, Middle, L Mary	Clementine	Smith	Aquilea		2. Date of De Month Augus	Day Day	Year 005	3. Time of Death 8:45 P. M	
	Examin		4a. Facility Name (If not institution, g			4b. City, Town,	or Location of D	eath	4c. Count	y of Death		
		ш	Forestville Heal	th & Rehabi	litation	Center	Foresty		Pri	nce Ge	orges	
	Funeral Director		5. Social Security Number 6. 577–42–5168	Sex 7. Age (1 ☐ M 2 🗶 F	n yrs. last birthda 75 Yrs.	Months Days		Hrs. 8. Date of Bin (Month, Da June 2 .	2, 1930	9. Birthpl Count Washi	ace (State or Foreign try) Lngton, D (
	and *		Usual Residence of Decedent 10a. State 10b. County	11	0c. City, Town or	Location				10	Od. Inside City Limits	
	Aaryli F sho	5		_	Colum					1.0	1 Yes 2 No	
	the N	ect	Maryland Howan	d	COTUM	10f. Zip Code			10g. Citizen of	What Count		
	with 3a or	<u> </u>	5933 Grand Bank	s Road			044		United		,	
36	be filed within 72 hours after death with the Maryland tal Hygiene. dother than "naturel", or items 23a or 28e-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Even Armed Forces?	er in U.S. 1	3. Was Decedent of If Yes, specify Cut	Hispanic Origin? pan, Mexican, Po	? (Specify Yes or No uerto Rican, etc.)	0- 14. Ra Bla	ice - America ack, White, e	an Indian, etc.	
Maryland 21215-0036	e filed within 72 hor al Hygiene. I other than "nature vent, the Medical E	Completed by	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education trade completed) College (1-4or 5+)	(Gi	cedent's Usual Occu ve kind of work done b. DO NOT use retire	during most of ed)		1	pt. of	Defense	
2	filed w Hygier Sther ti		12th grade	-41	In	telligenc	, , ,		1		rity Agend	
and	ld be fi ental H ked ot c ever	o Be	17. Father's Name (First, Middle, La: Hiliary Thom		r.			Name (First, Middle .e Beatri				
ary	2 should be and Mental is marked o	2	19a. Informant's Name/Relationship			ailing Address (Stree	1				Code)	
	1 and 2 Health a tem 27 is		Allison Beatrice	Smith (Nie	ce) 455	7 Akron St	treet;]	Cemple Hi	lls, Ma	ryland	20748	
ore	of He of He litem	35	20a. Method of Disposition 1 Burial 2 Cremation 3	Domewolfrom Chate	20b. Place of Dis	sposition (Name of rematory or other pla		g.31°,2005			The second secon	
Ĕ	Pages ment of tent: If it jury or o		'4 □ Donation 5 □ Other (Spec		Chesape	ake Crema				ille,M	Maryland	
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 is marke any njury or other freumatic <u>once.</u>		21. Shnature Funeral Service Concluded	BALL			edy Stre	et,N.W.;	Vashing	, Inc.	C. 20011	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	Prrysician		Immediate Cause (Final disease or condition	SELEBA	OVASC	WAR	ACCI	20130	_	1	Onset and Death	
h	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	NOTIC				ALCO	me inch	
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	consequence of):	ACHE	CATCO	NO AT C	CURL	DISA	was sa	
8760,	icate be executed physician and s the burial-transit	dical E	rosumy in death) cast	Due to (or as a d	consequence of):							
O. Box 6	death certif e attending d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 【 No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at tin 9□Unknown	Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	ey			ate of deliver	ry Day Year	
rds, P.	es tha	by	Part II. Other significant conditions DIABETE	contributing to death but	not resulting in the	underlying cause gr	ven in Part I.		tobacco use cor		e cause of death?	
I Records,	The law ate has b page 2 sl	Completed			-			24a. Was auto perfo		prior to com death?	sy findings available apletion of cause of	
Vital	clen: ertific sctor,	Be	25. Was case referred to medical examiner?				26. Place of	Death Check on	_			
of	Physiclen: this certific ral director,	은	1 ☐ Yes 2 🗶 No	Hospital: 1 Inpatient	2 ER/Outpat	Ient 3L DOA		g Home 5 ☐ Resi	dence 6 🗆 Ot	her (Specify,)	
N C		inol in	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	(ear) 28b. Time Injur	y Wo		28d. Describe	how injury occu	rred		
isic	Attending r death. sctor: After by the funer	icat	2 Accident investigat 3 Suicide 6 Could not	he	As been form		Yes 2 No	706 1	(D)			
Division	를 <mark>긁</mark> 를	ertification;	4 Homicide determine	building, etc.	(Specify)	street, factory, office		City or To	Street and Num wn, State)	ber or Hurai	Houte Number,	
	Hospite 4 hours Funerel ely filled	edical Co	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best of aminer: On the basis of earth and manner state	camination and/or	eath occurred at the t investigation, in my	ime, date and pl opinion, death o	ace, and due to the courred at the time,	cause(s) and m	anner as sta , and due to	ated. the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Date sign	ed (Month, D	Day, Year)	
			111			D-	- 183	45	August	25	2005	
1	シ 2×		30. Name apoless of person wh	o completed cause of dea	th (Item 23a) (Typ	ne, Print)			J. 3	- (-	20602	
_				у, М.Д.; 120		l Line Cen	ter; Su	ite 207;	Waldorf	, Mary		
	Sta Regist		31 AUG 9 (Manth 2005 ear)	32. Registrar								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0.5

			1- For State of Maryland / Depar Registrar Certif	tment of Health and Mificate of Death		jien @ 0 0 5	29884
h	Physici /Medi		Decedent's Name (First, Middle, Last) HILDA C • ANTHONY		2. Date of Dea Month SEPT •	8 2005	11:14a M
-0	Examir Funeral	ner	Chester River Manor	4b. City, Town, or Location of Death Chestertown If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Kent	ath rthplace (State or Foreign
	Director		219-34-4173 1 □ M 2 F 99 Yrs. Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local		May 15	, Year) C	ryland
	th the Maryla or 28a-f shov e notified at	Director	MD Kent Kennedyv 10e. Street and Number		1	0g. Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2√2 No ountry?
36	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23a or 28a-f show avant, the Medical Evantirer must be notified at	by Funeral D	1 Never Married 2 Married 1 Yes 2 Tho	21645 as Decedent of Hispanic Origin? (Spr yes, specify Cuban, Mexican, Puerto ☐ Yes 2♥ No Specify:		U • S • A • 14. Race - Am Black, Wh Specify:	
Maryland 21215-0036	filed within 72 hou Hygiene ther then "natura int, the Medical E	Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 15. Decedent's Education (Give kir life. DC School	nt's Usual Occupation nd of work done during most of work DNOT use retired) L Bus Contract		16b. Kind of Business	
ryiana	should be filk ind Mental Hy s marked oth umatic avant	To Be	17. Father's Name (First, Middle, Last) Lewin Chrisfield	18. Mother's Name Annie S	lagle		
Baltimore, Mar	permit. Pages 1 and 2 should be fi Department of Health and Mental H Important: If Itam 27 is marked ot any injury or other traumatic avan once.	1	Deborah Price (granddaughter) F 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21 Storms Junear Strates and See		till Po Pate /05	ond, MD. 20c. Location - City of Chester	21667 Town, State
	Physician and //Medical bhysician and //Medical transit the purial-transit	Examiner	23a Part. Enter the disease, or complications that caused the death. Do not enter shock, or healt failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reaums to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	the mode of dying, such as cardiac of Heart fan	t. Gale	ena, MD.	Approximate Interval Between Onset and Death
.O. BOX 68/6U,	attending for use a	Physician/Medical		ctopic pregnancy other (specify)		23d. Date of de Month	livery Day Year
cords, r	w requires that the dipension of the speed of the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.	1 ☐ Ye		robably 4 Unknown
итат жес	The la ate has page 2	e Completed	25. Was case referred to medical	26. Place Death	24a. Was ar autops; perform	ned? death? 2No 1 ☐ Yes	utopsy findings available completion of cause of
ō	ding Phys I. After this funeral di	ertification; To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation Hospital: 1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	3 DOA Other: 4 Nursing Hon 28c. Injury at Work? M 1 Yes 2 No	me 5 Reside 28d. Describe ho	nce 6 Other (Spe w injury occurred	
	To tha Hospital or Attend within 24 hours after death To tha Funaral Diractor: completely filled in by the	O	3 Suicide 4 Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify) 29a. Certifler 1 Certifying Physicien: To the best of my knowledge, death or		City or Town		
	To tha Ho within 24 h To tha Ful completely	Medical	(Check only 2 Medical Exeminer: On the basis of examination and/or invessione) 29b. Signature and the of certifier	stigation, in my opinion, death occurre	ed at the time, da	te and place, and due	to the cause(s)
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print 200, CO	,		9/9/0	55
	Sta Registr		Andrew S. Ferguson, M.D. 120 S 31. Date filed (Month, Day, Year) SEP 1 3 2005	peer Rd. Chest	tertown	i, MD. 21	620

		1	For State Registrer	State of N	Maryland /	Depart Certin	ment of H	lealth a Death	and Me	ental Hyg	giene No. No.	005	29885
	Physici		1. Decedent's Name (First, Middle, La							2. Date of Dea Month	Dav	Year	3. Time of Death
	/Medic	al	Harry Adelso la. Facility Name (If not institution, giv		or)	- 4	b. City, Town, o	r Location o		August		2005 unty of Death	6:25 A ^M
	Examin	er	sa. Facility Name (If not institution, gw Suburban Hos		91)	1	Betheso	_	or Death			ntgome	ry
	Funeral		5. Social Security Number 6. S		Age (In yrs. last	N	f Under 1 Year fonths Days	If Under Hours	24 Hrs. 8	B. Date of Birt (Month, Day	h (, Year)	9. Birthr	place (State or Foreign
	Director		577-28-1643 Usual Residence of Decedent	X M 2□F	80	Yrs.]	Dec. 20), 192	24 Wash	ington,D.C.
	/land	F	10a. State 10b. County		10c. City, To	own or Local	tion						10d. Inside City Limits
	e Man	ctor	Maryland Montgom	ery	Bethe	sda							Yes 2□No
)	with the Maryland a or 28a-f show the notified at	Die	10e. Street and Number				10f. Zip Code 20814				-	of What Cou	ntry?
tme of veath	£ 53	Funeral Director	10309 Dickens Ave	12. Was Decede		13. Wa	s Decedent of H	lispanic Ori	igin? (Spec	ify Yes or No		Race - Ameri	
9 6	a 2 5		1 Never Married 2 Married	1 Xes 2	⊔no Navy	7	es, specify Cubi	an, Mexicar Specify:		lican, etc.)		Black, White, Decify: Wh	etc. .ite
(4) E	within 72 hours efter ene. then "natural", or Ite	d by	3 Widowed 4 Divorced	Year or Date									
9.1	in 72 h	Completed	15. Decedent's E (Specify only highest gr	ade completed)		(Give kir	nt's Usual Occup nd of work done NOT use retire	during mos	st of working	9	160. Kind	of Business/In	laustry
3 5	d withing on the strain of the	mo:	Elementary/Secondary (0-12) 12 Years	College (1-4	or 5+)	Me	rchant					Liquor	
千百	tal Hygin	Be	17. Father's Name (First, Middle, Las	1)						(First, Middle, chneibe		ımame)	
- 5	and years. 2 should be fand Mental ? s marked of s mark	၉	Samuel Adelson 19a. Informant's Name/Relationship	(Type Print)		10h Mailing	Address (Street					own State Zi	n Code)
3 5	Mal		Marilyn R. Adelso		1	-	Dickens						20814
10	s 1 and 2 if Health Item 27		20a. Method of Disposition		20b. Place	e of Disposit	ion (Name of tory or other pla	ce)	Da	ate	20c. Loca	tion - City or T	
2	nit. Pages artment of hortant: If its injury or of		1 🖾 Burial 2 □ Cremation 3 l 4 □ Donation 5 □ Other (Spec		Beth	ı Shol	om Cong	•	8/24/	2005	Capito	ol Heig	hts, Md.
0625am the of De	partitions, interpretation to the permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Imporation the filem 27 is marked other then only injury or other treumatic event, the money.		21. Signature of Funeral Service Lie	Xter	themes	2 Da	Name and Addre nzansky 70 Rock	-Gold	berg	. Rock	ville	apels,	Inc.
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that cau	used the dann. I ch line.	Do not enter	the mode of dyi	ng, such as	s cardiac or	respiratory a	rrest,	Section to the p	Approximate Interval Between Onset and Death
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$\sqrt{}$	/Medical Examiner		resulting in death)	Due to (or	ras a consequen		EM (A	L					
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7	cuted nd rransit	Examiner	that initiated events	c			14661	TIS					
3	8 / bU, sate be executed obysicien and the burial-transit		resulting in death) Last	Due to (or	r as a consequer	nce of):							
	68/ (ificate to g physical as the b	dlcal		d									
8	ox nodin use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnancy	y anth and	ctopic pregnanc				230	d. Date of deliv	
٠,	Cords, P.O. Bowellest that the deatt been signed by the attestoolid be detached for	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of deat		Other (specify) _	. у				Month	Day Year
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5	dS, Fuires that signed detected	ρ	Faith. Other significant conditions	Contributing to dea	tir but not resulti	ng in the uno	ionying cause gi	* OT 11 1 C. 1.	•		Yes 2 🖵		babiy 4 Unknown
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		BeC	25. Was case referred to medical examiner?		##SS					(Check only	оле)		
Ž:	this al di	T ₀	1 ☐ Yes 2 € No			VOutpatient						Other (Spec	nfy)
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: ت	Division or Attending after death. Director: Afte	flca	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of	of Injury - At hom	e, farm, stree	et, factory, office		2		Street and wn, State)	Number or Ru	ral Route Number,
9	DIVI	Cert	4 Homicide	Buildin	g, etc. (Specify)					- CNY 0/ 10	wii, Siale)		
A	Divi	Medical Certification:		Physician: To the teminer: On the base and manner	sis of examination								
	To the within 2 To the complet	Ž	29b. Signature and title of certifier	0	4.6	^		nse number		* .		signed (Month	-
	15		· m		· m			05	112	4	8	1221	03
			30. Name and address of person we Truong Bao,	MD 1	3219 Ex	ecutiv		Terra	ce, G	ermant	own, l	MD 2087	4
	S Regis	tate trar	31. Date filed (Month, Day, Year) AUG 2 6	2005	egistrar's Signatu	re Apr	ules						

			For State Registrar	State of Maryland / Depa	rtment of Health and l		ene 9. N2 0 0 5	29886
			Decedent's Name (First, Middle, Las			2. Date of Death	1	3. Time of Death
	Physici		FREDERICK LEWIS	BARNO		Month August	Day Year 2005	11:20 A ^M
	/Medic Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Deat		4c. County of Death	
	LAGITHI		3317 Chauncey Pla	ce, Apt. #303	Mt. Rainier		Prince Ge	orge's
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day,		place (State or Foreign
	Director		579-78-8080	M 2 F 47 Yrs.	Montals Days Hours Mill.	June 6,	1958 Was	hington, DC
	D .		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	antion			10d Incide City Limits
	sho	5						10d. Inside City Limits 1 Yes 2 No
	the N	Director	MD Prince G	eorge's Mt. Rain	10f. Zip Code	10	Og. Citizen of What Cou	
	with with			#202				muy:
	eeth	eral	3317 Chauncey Pla 11. Marital Status		20712 Vas Decedent of Hispanic Origin? (S	necify Yes or No-	U.S.A.	ican Indian
10	ther d	Funeral	1 ☑ Never Married 2 ☐ Married	Armed Forces? If	Yes, specify Cuban, Mexican, Puer	o Rican, etc.)	Black, White	
336	urs af	6	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give 1 Year or Dates:	☐ Yes 2X No Specify:		Specify:	lack
ō	within 72 hours after deeth with the Maryland ane. than "natural", or Items 23a or 28a-f show than "sedical Exercence" insafter notified at	ted	15. Decedent's Ed	ucation 16a. Deced	ent's Usual Occupation	,.	6b. Kind of Business/li	
215	Pin 7	ple	(Specify only highest gra- Elementary/Secondary (0-12)	College (1-4or 5+)	kind of work done during most of wo. OO NOT use retired)	rking		
21	e filed withi al Hygiane. I other than vent, than	Completed		4 Cour	ier		Hertz	
Maryland 21215-0036	be filed within 72 hours after deeth with the Marylan ital Hyglane. Id other than "natural", or flems 23a or 28a-f show event, the Mardical Experience must be notified at	Be (17. Father's Name (First, Middle, Last)		18. Mother's Nar	ne (First, Middle, M	faiden Sumame)	
yla	should be and Mental marked o	2	Lewis Barno		Ella P	roctor		
lar	2 sho and Is mu		19a. Informant's Name/Relationship (7		g Address (Street and Number or Ru			
	교육성급		Nadell Scott, Fri		Sandy Point Cou			
Baltimore,	of Head of Head If item or othe		20a. Method of Disposition 1	Removal from State 20b. Place of Dispose cemetery, cren	sition (Name of natory or other place)	Date 2	20c. Location - City or T	own, State
Ĕ.	permit. Pages 1 Department of I Important: If ite any injury or ot		* 4 Donation 5 Other (Specify	Harmony (Landover, M	
Sall	eparti eparti porti ny in		21. Signature of Fureral Service Licen	S86 22	Name and Address of Facility G	asch's Fu	neral Home	, P.A.
_	90 E 9 9		+auest (39 Baltimore Ave			yland
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications of caused the death. Do not enter one cause in each line.	er the mode of dying, such as cardia	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease of condition		Onset and Death			
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):				
	TITE A	-	Sequentially list conditions,	b. — Due to (or as a consequence of).				
	ted slt	Examine	ii any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence or).				
	be executed sicien and burial-transit	xar	that initiated events resulting in death) Last	c. Due to (or as a consequence of):				
8760,	sicier buris	dical E	l l	4-				
687	death certificate be executed e attending physicien and od for use as the burial-transit	edic		u.				
ŏ	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of deliv	rery
m.	death e atte d for	cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of death 5☐	Ectopic pregnancy Other (specify)		Month	Day Year
0	at tha de by the a tached	hys	9 Unknown	9□ Unknown				
S, P	The law requires that tha the law seen signed by the bage 2 should be detache	by P	Part II. Dther significant conditions of	ontributing to death but not resulting in the ur	derlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ğ	quire an sig	ed				1 ☐ Ye	s 2□No 3□Pro	babiy 4XJUnknown
Record	aw requisite been 2 should	Completed				24a. Was an		opsy findings available
Ä	The law ate has page 2	Eo				autopsy perform	ed? death?	ompletion of cause of 2 No
Vital		O	25. Was case referred to medical		26. Place of De	ath (Check only one	A	
>	di S	To B	examiner? 1 X Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	Cther: 4 Nursing H	lome 5 Reside	nce 6 Other (Speci	fy)
J of			27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury 28b. Time of (Month, Day Year) Injury	28c. Injury at Work?	28d. Describe ho		
Ö	uttending death. ctor: After y the funer	atic	2 Accident investigation		M 1 ☐ Yes 2 ☐ No			
Division	l or Attendate death	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office	28f. Location (Str. City or Town,	eet and Number or Rui , State)	al Route Number,
	itel o			,				
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Attencompletely filled in by the fune	Medical	(Check only 2 ☑ Medical Exam	ysician: To the best of my knowledge, death niner: On the basis of examination and/or inv	occurred at the time, date and place restigation, in my opinion, death occurrence.	, and due to the ca irred at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
	To the within 24 To the ficomplete	Med	29b. Signature and title of certifier	and manner stated.	29c. License number	20	d. Date signed (Month)	Day Year)
	5 7 K 7		1-2-1	N Aleste To				
			20. Nama and address of parent who	completed cause of death (Item 23a) (Type,	H55927	P	ugust 26,	
-	i		Salvador Sylveste		al Drive, Chever	ly, Marvl	and	
	Sta	ate						
	Regist		31. Date filed (Month, Day, Year) AUG 3 0 2005	32. Registrar's Signature	,			

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Ma	rylan	•	rtmen tificate			and M		Reg. No	0.5	29887
	Physici	an	Decedent's Name (First, Middle, Last)	0 1							2. Date of Dea	26, Day 200	5 ^{Year}	3. Time of Death 4:18 A M
	/Medic	al	Martha Rebecca 4a. Facility Name (If not institution, give s				4b. City.	Town, or	Location of		August	4c. County		
	Examin	er	Southern Maryland	_			-	Clint						eorge's
	Funeral Director		219-56-0431	M 201 7. Age	(In yrs. i 57	ast birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birt Month, Da June 5,	^h 1948	9. Birth Cou New	place (State or Foreign Dersey
	e Marylend le-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Ge	orge's		v, Town or Lo				-				10d. Inside City Limits
	with the	Dire	10e. Street and Number	l-i-b+- Da			10f. Zip	Code 206	:12			10g. Citizen of V		ntry?
036	permit. Peges 1 end 2 should be filed within 72 hours efter death with the Marylend Depertment of Heelth and Mental Hyglene. Importent: if Item 27 is marked other then "natural", or Itams 23a or 28e-f show importent: if Item 27 is marked other then "natural", or Itams 23a or 28e-f show all high right in result to nutilised at an angle.	by Funeral Director	14505 Brandywine H 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🕱 N If Yes, Give Year or Dates:	ver in U.		Was Deced f Yes, spec	lent of His		gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)		e - Ameri ck, White,	can Indian, etc. ite
1215-0	within 72 ho ene. then "natur he Madical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation o completed) College (1-4or 5	+)		lent's Usua kind of wor DO NOT us 1emake	rk done d e retired)	tion luring most	t of worki	ing	16b. Kind of B	usiness/lr	
Maryland 21215-0036	should be filed and Mental Hygic marked other umailc event.	To Be Co	17. Father's Name (First, Middle, Last) Charles Hankins				Temak				ilable	Maiden Surnan		
	1 end 2 sho Heelth and I em 27 Is me		19a. Informant's Name/Relationship (Ty) Warren W. Beale -	-		14505	Brand	dywi		ight	s Rd.,		ine,	MD 20613
Baltimore,	permit. Peges 1 en Depertment of Heel Importent: If Item 2 eny Injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ R		Hur	lace of Dispo emetery, crem ntt Cre	ematory or or	ther place My	8	-30-		Waldorf	-	own, State
Balt	permit Depert Import any inj		21. Signature of Funeral Service License			H	Name an	Crema	atory			F, MD 20	604	
	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each lin	Θ.				3				Ł	Approximate Interval Between Onset and Death
8760,	Medical Examiner physiclen and the purial-transit	icai Examiner	Gequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or a) Due to (or a	a conseq	uence of):	Tag	£ (Colo	* 1	Come	7	ن د	~ léne~)
P.O. Box 68	auth certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No. 9 ☐ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 🗌 Feta	Ideath 3	Ectopic pro						te of deliver	ery Day Year
ecords, P.	quires that the de n signed by the uld be detached	by	Part II. Other significant conditions cor	ntributing to death bu	ıt not res	ulting in the u	nderlying ca	ause give	n in Part I.			obacco use cont	tribute to t	he cause of death?
Œ	The law requires tate has been sign page 2 should be	Completed										rmed?	Were auto prior to co death? 1 🗌 Yes	opsy findings available impletion of cause of
Vita	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	lospital:			-5	A Othe			(Check only o			
on of	Ilng After une	-	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injur (Month, Day	v	28b. Time of Injury		8c. Injury Work	4 🗆 190			dence 6 Oth		(y)
S see a la Homicide building, etc. (Specify)								28f. Location (S City or Tox		per or Rur	al Route Number,			
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one) Certifying Physical Examination	sician: To the best of ner: On the basis of and manner sta	examina	wledge, death tion and/or in	n occurred vestigation,	at the tim , in my op	e, date an inion, dea	d place, th occurr	and due to the ed at the time,	cause(s) and madate and place,	anner as s and due t	stated. o the cause(s)
L	To the within 2 To the complex	M	29b. Signature and title of certifier				290	. License	number			29d. Date signe	d (Month,	Day, Year)
			30 Name and address of Ulle	INV	agth //	0 (2a) (T	Drint'	0	17 4		F	+ ingcol	,20	0105
-	134		30. Name and address of person who co	empleted cause of de	ut (iten	3 -41	- 100	ve	100	in	MYD	20002	_	
	Sta Regist		31. Date filed (Monta, Day, Year) AUG 3 0 20	32. R sistra	ar's Signa	ture A	book	,		9				

State of Maryland / Department of Health and Mental Hygiene-For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Billie Jean Brady August 27, 2005 11:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Waldorf Healthcare Center Waldorf Charles | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | Oct. 29, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗙 F Yrs. Director 234-54-8178 69 1935 West Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Madical Examiner must be notified at 1 Yes 2 No Director Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5 4140 Old Washington Road 20601 Items 23a USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married Married ö Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: White ģ Specify 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry rthan Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Civil Service other permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 is marked oth eny lighty or other traumatic event social. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Woodrow Wilson Hughes, Sr. Constance Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John E. Brady - Husband 6306 Josephine Road, Waldorf, MD 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State MD Veterans' Cemetery 8-31-05 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M01391 P. O. Box 156 Huntt Funeral Home Waldorf, MD 20604 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cancel /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use es the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death 5 Other (specify) ed by the a Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 3 Probably 4 Unknown 1 □ Yes 2 □ No. Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After t Injury s after deau.
rel Director: Aftr 1 Natural 5 Pending 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel C Hospital 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. have be well 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9 OS D-0056949 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kamakshi Baig, MD 6620 Crain Hwy Suite 102 La Plata, Maryland 20646 31. Date filed (Month, State 0 2005 Registrar

				1- For State of Maryland / Department of Health and I Certificate of Death	•	^ກ ົ້ວກາຣ 20	889
				1. Decedent's Name (First, Middle, Last)	2 Date of Death	2 Tio	ne of Death
		Physici /Medic		HARVEY WELLWOOD BROWN	August	39, 2005 3:	00 A M
		Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	h O	4c. County of Death	
				Doctor's Community Hospital Lanham		Prince George'	S
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9. Birthplace (St	
		Director		516-03-5199 91 Yrs.	Sept. 27,	1913 Montana	
		and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d Insi	de City Limits
		Aary	ō				Yes 21 No
		ith the Marylan or 28a-f show	Director	MD Prince George's Riverdale 10e. Street and Number 10f. Zip Code	100		
		with se or	ā			Citizen of What Country?	
		death with the Maryland ims 23a or 28a-f show imst be notified at	Funeral	6007 Mustang Place 20737 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S		U.S.A. 14. Race - American India	0
2	S	ritar	듄	Armed Forces? 1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No 1942 — If Yes, specify Cuban, Mexican, Puert	to Rican, etc.)	Black, White, etc.	,
0	93	ai', o	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1946		Specify: White	
7	5-0036	72 ho	ted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work	16	b. Kind of Business/Industry	
	21	thin ?	nple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of work iffe. DO NOT use retired)	rking		
1	2121	ygien ygien t, th	Completed	12 U.S. Government		Analyst	
-	p	tal H d oth	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name	me (First, Middle, Ma.	den Sumame)	
3	yla	Men Arka atic	ဥ	George Thomas Brown Lela Sv			
SROWN	Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mandal Hygleine. Department of Health and Mandal Hygleine instruction; if I tem 27 is marked other than "natural", or items 23e or 28e-f show important; if I tem 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Magical Examiner must be notified an once.		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru			
0	2	and lealth m 27 har t		Catherine C. Brown, Spouse 6007 Mustang Place, Ri			
0	O	ges 1 t of H if its or ot		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20	c. Location - City or Town, Stat	е
00	Ē	ment tant:		`4 Donation 5 Other (Specify) MD_Veteran's Cemetery 08/		neltenham, Mar	
_	Salt	Departiment Departiment Important Income.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ga	asch's Fun	eral Home, P.A	۸.
	_	₽ □ = 9 9		H Constance Wasen 4739 Baltimore Ave			nd
				23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arrest	Interva	Between
		Pnysician		Immediate Cause (Final disease or condition a. Bilateral Aspiration Pneumonia		1 We	and Death
		/Medical Examiner		resulting in death) Due to (or as a consequence of):			
		Exammer		Sequentially list conditions. b. Chronic Respiratory Failure		5 Ye	ears
		p #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Advanced Chronic Obstructive Pulme			
		ecute and trans	cam	that initiated events c. Advanced Chilonic Obstituctive Fulling	onary Dise	ase 20 Ye	ears
	90,	cian s		Due to (or as a consequence or).		20. 77	
	Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	Dysphagia & Esophageal Stenosis		20 Ye	ears
	9 ×	leath certific attending p	Me	IF FEMALE:			
	Во	attendattende	lan	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fatal death 3 Ectopic pregnancy		23d. Date of delivery Month Day	Year
	P.O.	the de	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		,	r oui
	۵.	vrequires that the de been signed by the s should be detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did tobac	co use contribute to the cause	of doath?
	ds,	signe d be	d by	Hypertensive Cardiovascular Disease		2 □ No 3 □ Probably 4	
	Ö	w requir been si should	Completed				
	3ec	has has	mpl	History of Rt sided Lobectomy for Lung Cancer	24a. Was an autopsy	24b. Were autopsy findi prior to completion	ngs available of cause of
					performed 1 ☐ Yes 2X		
	Division of Vital Records,	Physician: The this certificate al director, pag	Be	Hospital: Other	ath (Check only one)		
	ot	Phys this ral di	To	TAI Inpatient 2 EH/Outpatient 3 DOA 4 Nursing H		e 6 □Other (Specify)	
	on	ding h. After fune	ton	1 X Natural 5 Pending (Month, Day Year) Injury Work?	28d. Describe how	njury occurred	
	S	Atten deat ctor; y the	Certification:	2 Suiside 6 Could not be	28f Location /Stree	t and Number or Rural Route I	Numbos
	Ξ	after Dira	erti	4 Homicide determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined	City or Town, S	tate)	vu <i>mber</i> ,
	_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.		29a. Certifier 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place	and due to the caus	e(s) and manner as stated	
		e Ho	edical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence)	rred at the time, date	and place, and due to the cau	se(s)
		To th withir To th somp	Me	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month, Day, Yea	ar)
)	. ^		1 Curaveal 1 001555	8	8/29/05	
		12		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		1 100	
MA	~	1 Ya		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SKUMAKAN C. ARXANGAT H.S. 3308 PERKLY STREE 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 3 0 7005	5ET M4 1	CAINIER MA.	297/1
		. Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Sign ture	7(.7	1711-165 100	1110
		Registr	rar	AUG 3 0 2005 Kleeve M. Space			

DHMH 17 Rev 1/2001

		•		epartment of Health and M Certificate of Death		2005 29890
	0		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia /Medic		Beatrice Virginia Bass		Month 08	Day Year 22 05 5:25 P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Laurel Regional Hospital	Laurel		Prince George's
П	Funeral		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthe	Months Days Hours Min	8. Date of Birth (Month, Day, Y	
	Director		229-26-2099 A 81	•	02 21	24 Pennsylvania
	yland		10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
	a-1 st	tor	MD Prince George's Colle	ge Park		¥3Yes 2 □ No
	or 28	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?
	ath w		5018 Iroquoij Street	20740		USA
	er de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	 Race - American Indian, Black, White, etc.
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 🔀 No Specify:		Specify: Black
21215-0036	2 hou	ted	15. Decedent's Education 16a. D	Decedent's Usual Occupation	16	6b. Kind of Business/Industry
2	hin 7. B. Bn "n Med	Completed	(Specify only highest grade completed) ((Specify only highest grade completed) ((Specify only highest grade completed) ((Specify only highest grade completed)	Give kind of work done during most of worki life. DO NOT use retired)	ng	
7	er the	Соп	2 yrs. Of	fice Manager		U.S. Government
nd	be file d oth even	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma	aiden Surname)
Z	ould Men Marke Parke	J.	Charles Brooks, Sr.	Emma Br		
Maryland	d 2 st th and 7 is n treun		End and the second seco	Mailing Address (Street and Number or Rura		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examinal multiplical at ODGs.		20a Mathad at Disposition 1200, Mace of L	Barrell Horse Drive	charle	Ston, WV. 25414 Oc. Location - City or Town, State
JOH.	Pages nent of ant: If its ary or o			nd National 09-03		aurel, MD.
altimore,	permit. F Departme Importer any injur		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Man	shall's	Funeral Home
Ö	in per per per per per per per per per per		O R marshall	4217 9th. St. N.W.	Washingt	on, D.C. 20011
			23a. Part1. Enter the disease, or complications that caused the death. Do no shock or heart failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac	or respiratory arres	t, Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Recurrent Can	cer of Pancreas		Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of			
	LAGITIIIICI	er	Sequentially list conditions, Thank leading to immediate the sequence of			
	ted 1sit	nine	cause. Enter Underlying Cause (Disease or injury	•		
	al-trai	Examin	that initiated events resulting in death) Last c. POST U erative Due to (or as a consequence of	Wound Infection		
8760,	icate be executed physicien and s the burial-transit	dicail	d			
9	tificat ng phy as th	Aedi				
Вох	th cer rendir r use	an/h	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	3 ☐Ectopic pregnancy		23d. Date of delivery
0	e dea he ati	sici	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death	5 Other (specify)		Month Day Year
<u>Ч</u>	The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as	Physician/Me	9 ☐ Unknown Part II, Other significant conditions contributing to death but not resulting in t	the undertains according to the latest the second of the s	23a Did taha	cco use contribute to the cause of death?
ds,	ires ti signe	l by	Gastric Outlet Obstruction	are underlying cause given in Part i.		2 No 3 Probably 4 Unknown
Ö	w requir	etec		1 1 .	-	
Vital Records,	has ge 2	Completed	Status Post - recent - Cerebrovas	cular Accident	24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
<u>a</u>	icien: The certificate harector, page	e Co	Cardiac Arrhythemic 25. Was case referred to medical	OC Place of Death	1 ☐ Yes 2x	No 1 Yes 2 No
5	Physicien: this certific ral director.	To B	examiner? 1 ☐ Yes 2 🛣 No	Othor	n <i>(Check only one)</i> me 5 ☐ Residen	ce 6 Other (Specify)
JO L			27. Manner of Death 28a. Date of Injury 28b. Tir		28d. Describe how	
joi	Attending r death.	atio	2 Accident investigation	M 1 Yes 2 No		
Division	l or Attencater death	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fam building, etc. (Specify)	n, street, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
Ω	Hospitel or 24 hours afte Funerel Dir tely filled in	O	_			
	To the Hospitel or Attenwithin 24 hours after deat To the Funarel Director: completely filled in by the	edicai	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, (Check only one) 2 Medicel Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place, or investigation, in my opinion, death occurr	and due to the cau ed at the time, dat	se(s) and manner as stated. e and place, and due to the cause(s)
	To the I within 2 To the I complet	Med	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month, Day, Year)
	+ × + ō		Dadmaja S. Udapr n	D. D24174		ugust- 23 vd 2005
6	(7)		30. Name and address of person who completed cause of death (Item 23a) (T			0.
14	0		Padmaja S. Udapi, M.D. 7350 Van		urel, M.I	20707
		ate	31. Date filed (Month, Day, Year) AUG 3 0 2005 Registrar's Signature	hack o		
	Regist	al	AUG 3 0 2005			

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician August 22, 2005 12:24 P.M. ETHEL BAILEY /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Mitchellville Pri
ar | If Under 24 Hrs. | 8. Date of Birth
ys | Hours | Min. | (Month, Dey, Year) 10105 BALD HILL ROAD Prince George's 5. Social Security Number 7. Age (In vrs. lest birthday) Funeral Birthplace (State or Foreign Country) Months Deys 1 ☐ M 2 🖫 F 89 Director 266-36-6097 Usuet Residence of Decedent Oct. 4, 1915 Tallahassee,FL the Marylend 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits aho∉ Department of Heelth and Mentel Hyglene. Important: if Item 27 ie marked other than "naturel", or itema 23a or 28a-1 ahov eny Injury or other treumatic event, the Medical Examiner must be notified at 1 A Yes 2 □ No Director Maryland Prince George's Mitchellville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 10105 BALD HILL ROAD 20721 U.S.A. e filed within 72 hours after death is el Hyglene. I other than "naturel", or items 23s Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 2 Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 M No Specify: Specify: Black 2 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6th Domestic Private Industry 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) B Leila Ardley Oscar James, Sr. 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Dorothy L. Ribbon/daughter 10105 Bald Hill Rd. Mitchellville,Md. 20721 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Pages 1 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Clifford Hill Cemetery 8/30/05 Tallahassee, Florida 21. Signature of Funeral Service Licensee Frazier's Funeral Home, Inc. 1013-20 389 Rhode Island Ave., N.W. Wash., DC 20001 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Finel disease or condition resulting in death) /Medical CEREBROVASCULAR ACCIDENT Examiner Due to (or as e consequence of): Examine HYPERTENSION The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, DEMENTIA Physician/Medical Due to (or as e consequence of): DECUBITUS ULLER Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 □ Probably 4 X Unknown ξ 24b. Were autopsy findings available prior to completion of ceuse of deeth? Completed 24a. Was an autopsy certificate has 1 🗌 Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? B 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2□ No After this completely filled in by the funerel 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Netural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 - Homicide ò To the Hospital of within 24 hours at To the Funerel D 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 8/25/05 D0061446 MD 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Lanham, Md. 20706 9470 Annapolis Road Suite 315 Kalaiselvi Ayyanar, MD 31. Date filed (Month, Day, Year) 32. Registrer's Signature State

DHMH 16 Rev 6/95

Registrar

AUG 3 0 2005

ORIGINAL

State of Maryland / Department of Health and Mental Hygieng 00 29892 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Year Aug. 25, 2005 Ruth Bari 4:20 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Rockville Montgomery National Lutheran Home ff Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Nov. 17, 1917 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 ☐ M 2 💢 F 87 121-07-8079 Yrs. New York Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits or items 23a or 28a-f show the Medical Examiner must be notified at Md. Montgomery Rockville 1X Yes 2 □ No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20850 9701- Veirs Drive r death v by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 'naturai' Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Efementary/Secondary (0-12) College (1-4or 5+) Math Professor G.W.University Δ nd 2 should be filed aith and Mental Hygid 27 is marked other raumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Isser Aaronson Rebecca Gersky ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Bari - Daughter 6413-Rock Forest Dr., #102, Bethesda, Md. 20817 item 27 i Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or otl 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metropolitan Crematory-8/26/05-Alexandria, Va. *4 □ Donation 5 □ Other (Specify) 21. Signature of Fundral Service ice 22. Name and Address of Facility Hysong Co., Inc. 6510-16th St., DO St., NW, Wash., DC ardiac or resciratory arrest, 23a. Part1. Enter the disease, or com shock, or heart failure. List only ns that cal sed the death. Do not enter the mode of sing, such as cardiac or Approximate Interval Between Onset and Death Immediate Cause (Finaf disease or condition resulting in death) Physician pars /Medical Examiner ll bequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and I-transit The law requires that the death certificate be executed Exami Due to (or as a consequence of): burial-Box 68760. Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of cate has t prior to c death? 1 Yes certificate Yes 2□ No Division of Vital 2 No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after death Puneral Director: 6 Could not be determined 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 T Homicide filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 2005 auestr V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr.Charles Karesh- 9701-Veirs Dr., Rockville, Md. 20850 W. State Registrar AUG 3 0 2005

			For State Registrar	State of M	aryland / Dep <i>Ce</i>	ertificate of L			giene Reg. N	005	298	93
ı	Physicia		1. Decedent's Name (First, Middle Clifford Verne		1.1.1			2. Date of De Month	Day	Year 2005	3. Time of 4:10	Death
	/Medic Examin		4a. Facility Name (If not institution			4b. City, Town, or	Location of I	August Death		County of Death	14:10	<u>r</u>
		*	Montgomery Ho			Rockvi1				Montgom	ery	
	Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last birthday Yrs.	Months Days		Min. (Month, Da	h y, Yea <i>r)</i>	9. Birthr	place (State ontry)	or Foreign
	Director		519-07-3437 Usual Residence of Decedent		85 trs.			Aug. 23,	1920	Idal	10	
	yland yland		10a. State 10b. County		10c. City, Town or I	ocation.				1	0d. Inside Ci	ity Limits
	e Mar	ctor	DC		Washingto	on					1X Yes	2∐No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Cîtize	en of What Cour	ntry?	
	s 23a	rai	3700 North Cap				11-840		$\overline{}$	USA		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "natural', or Items 23a or 28e-f show amy lury or other traumatic avant, Ira Madical Exercity at most ten cultifications.	by Funerai	11. Marital Status 1 □ Never Married 2 □ Marri 3 ☒ Widowed 4 □ Divorced	If Vas Giva	? No	. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin n, Mexican, F Specity:	n? (Specify Yes or No Puerto Rican, etc.)		4. Race - Americ Black, White, Specify:	etc.	
Maryland 21215-0036	2 hour	ed b	15. Decedent	Year or Dates:	16a. Dec	edent's Usual Occupa	ation		16b. Kine	Wh d of Business/in	ite	
215	hin 72 an "na Medil	Completed	(Specify only highes Elementary/Secondary (0-12)	completed) College (1-4or	(Giv	e kind of work done of DO NOT use retired	turina most o	f working		3 01 B301100G111	33311)	
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nd	be file tal Hy d oth avant	Be (17. Father's Name (First, Middle,				18. Mother's	s Name (First, Middle,		lumame)		
<u></u>	ould I Men narke natic	T _o	William Ray Bu				E11e					
<u>g</u>	d 2 sh th and 17 is n traun		19a. Informant's Name/Relations	Daughte	er			or Rural Route Numbe				
re,	tem 2		Rebecca E. L. B	utterrierd	20b. Place of Disc	Riggs Roa		tonsville.		y Land ation - City or To	20882 own, State	
E C	Pages ent of nt: If i		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)			ematory or other plac can's Cemetery	θ) Λ.,	ıg.31,2005	Cho1	tonham 1	Maren 1 a	nd
Baltimore,	mit. I partm porte finju		21. Signature of Funeral Service				s of Facility	s Funeral	CHET	temam,	лагута	IIG
<u> </u>	Pe m m g		/ best (1 / fr	50	O Univers	ity B1	vd.,W.,Si	ноте Lver	, inc. Spring,	MD 209	01
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each !	d the death. Do not e	nter the mode of dyin	g, such as ca	urdiac or respiratory a	rest,		Approximate Interval Bety	ween
	Pnysician	2	Immediate Cause (Final disease or condition resulting in death)	_aIschem	ic Cardiom	opathy					Onset and [Death
	/Medical Examiner		resulting in death)		a consequence of):							
	NAME OF	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as	s a consequence of):							
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o,	ate be executed hysician and the burial-transit	Exa	resulting in death) Last		a consequence of):							
8760,		dicai		d								
9	death certific e ettending p ad for use as	/Mec	IF FEMALE:	23c. If yes, outcome	of pregnancy							
Вох	eath certific ettending p for use as	cian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			23	Id. Date of delive Month	,	Year
O.	that the de led by the e detached f	nysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown								
٣,	The law requires that the te has been signed by th bage 2 should be detache	by Physician/Med	Part II. Other significant condition	ons contributing to death	but not resulting in the	underlying cause give	en in Part I.	23e. Did to	obacco us	e contribute to th	ne cause of d	eath?
ğ	w require been sig should b							_ 101	/es 2 □	No 3 ☐ Prob	abiy 4 🛣 ∪	Jnknown
Vital Records,	e law re has be je 2 sho	Completed						24a. Was		24b. Were auto	psy findings a	available
<u>=</u>		Con						perfo	med? 2⊠No	death?	2□ No	
Vita	Phyaiclan: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othe		Death Check on o				
ō	Phys r this ral dii	7.	1 Yes 2 No 27. Manner of Death	1 🔲 Inpati	ient 2 ER/Outpatie	ent 3L DOA	4 Nursi	ing Home 5 Resid			Hospi	ce
on	th. : After s tuner	tior	1 XNatural 5 ☐ Pendin 2 ☐ Accident investig		ay Year) Injury	Worl	c? Yes 2∐No			00001100		
Division of	If or Attendi after death. Diractor: A d in by the fu	Certification;	3 Suicide 6 Could in determine	ined 286. Place of In	njury - At home, farm, s	treet, factory, office		28f. Location (S	Street and	Number or Rura	l Route Num	ber,
	tal or rs afte al Dir ed in	Cert	- Cromodo	bullding, e	ic. (Specify)			City or Tov	m, State)			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physician: To the best Examiner: On the basis of and manner s	of examination and/or i	ith occurred at the tim nvestigation, in my of	e, date and pointon, death	place, and due to the occurred at the time,	cause(s) a date and p	nd manner as si place, and due to	ated. the cause(s	.)
	To the l within 2 To the I	Ž	29b. Signature and tilla o certific	IND		29c. License	number		-49	signed (Month,		
)	311		CALL	The		104	121	18	8-	25-0	5	
			30. Name and address of pers									
			Charles Harri 31. Date filed (Month, Day, Year)				Road	Rockville	,Mar	yland	20855	
	Sta Registr		AUG 3	0 2005	we do	horlis						

State of Maryland / Department of Health and Mental Hygiens Reg. NO. 005 29894 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Benjumea Jesus Octavio Aug. 25, 2005 11:55pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Examiner 10920 Connecticut Ave #G-5 Kensington 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Month Day Year 28 **Funeral** 9. Birthplace (State or Foreign Months Days 100-50-6574 11 M 2 ☐ F Hours 77 Director Colombia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel" or iteme 23e or 28e-f ehow eny injury or other traumatic event. Its Madical Examiner must be notified. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Montgomery Kensington MD 1 Tyes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10920 Connecticut Avenue #G-5 20895 Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1X Yes 2□ No Specify: Colombian White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) China-Dishware Factory 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Maria Arredondo Timoteo Benjumea 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
19917 Mastenbrook Pl. Montgomery Village, Md 19a. Informant's Name/Relationship (Type, Print) Olga Benjumea/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
All Souls Cem. Date 20a. Method of Disposition 20c. Location - City or Town, State Method of Disposition

1 ⊠Burial 2 □ Cremation 3 □ Removal from State 8/29/05 Germantown, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Foreral Service Life PHILIPADS RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death **Physician** Brain Tumor disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use es the burial-transit The law requires thet the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death Month Year 5 Other (specify) ed by the a deteched f 9 Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been si Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No this certificete hes al director, page 2 s autopsy performed? Yes 2 No 1 Yes To the Hospitel or Attending Physician: After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 🗷 Residence 6 Other (Specify) Hospital: ဥ 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pendina investigation 1 Yes 2 No i Director: / d in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D003293 August 28,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick Smith MD. 5454 Wisconsin Avenue Chevy Chase, Md 20815 31. Date filed (Month, Day, Year) 32 Registrar's Signature State AUG 3 0 2005 Registrar

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			For State Registrar Amend # 29	State of d.Per Phys.	Maryland / De PGC 8-31-05cm	epartment of Certificate of	f Health a of Death	and Mental Hyo	giene 005	29896
9	Physicia		1. Decedent's Name (First, Middle, John J.	Last)	2. Date of Dea Month	Day Yea				
7	/Medic Examin		4a. Facility Name (If not institution,	August	4c. County of De					
	LAdimir		Southern Ma	rvland Ho	spital		Clint	on	Prince	e George's
	Funeral			S. Sex	7. Age (In yrs. last birtho	Months Da	ar If Under 2			irthplace (State or Foreign Country)
	Director		215-20-3999	1 XM 2□ F	85 Yr	i.	73 110013	July 12		Maryland
	and **	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town of	r Location				10d. Inside City Limits
	Maryl f sho	ō	Maryland Princ	e George'	s		Largo			1 X Yes 2 □ No
	r 28a	Director	10e. Street and Number			10f. Zip Cod			10g. Citizen of What (Country?
	h with		700 Avis D	rive			2077	4	United	States
	deet	Funeral	11. Marital Status		dent Ever in U.S.	13. Was Decedent		gin? (Specify Yes or No- , Puerto Rican, etc.)		nerican Indian,
98	or it	J.	1 Never Married 2 Marrie	d 1 XYes If Yes, Give	2 No	1 ☐ Yes 2 🔯 1		, 1 3 3 1 5 1 1 3 2 1 7 3 2 5 7		African
ö	i 72 hours efter deeth with the Marylan "natural", or itama 23a or 28a-f show olical Examiner must be mollified at	d by	3 XWidowed 4 □ Divorced	Year or Da	ites:				E	merican
21215-0036	within 72 hours efter deeth with the Maryland ene. than "natural", or itama 23a or 28a-f show the Modical Examiner must be notillied at	Completed	15. Decedent's (Specify only highest	grade completed)	(9	ecedent's Usual Oc Rive kind of work do fe. DO NOT use re	ne during most	of working	16b. Kind of Busines	s/Industry
212	filed within Hygiene. Sthar than ant, the Ma	E o	Elementary/Secondary (0-12) 7 th	College (1-	-4or 5+)	Bottle Ga	as Tech	nician	Priv	vate
٦	be filed within 72 ho ital Hygiene. dothar than "natul evant, the Modical	Bec	17. Father's Name (First, Middle, Li	ast)				r's Name (First, Middle,		
<u>Ja</u>	Menta	To E	Charles	L. Brice				Mandy	V. Butler	
Maryland	is 1 and 2 should be filed vor thealth and Mental Hygie item 27 is marked other to other traumatic event, In		19a. Informant's Name/Relationshi					r or Rural Route Numbe		, Zip Code)
	tam 27 tames 1 tam 27 t		Kenneth J. Br	ice - Son		UU AVIS I	-	Largo, MD	20774	-
Baltimore,	Pages Inent of Hunt: If its		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3		State cemetery,	crematory or other	place)		20c. Location - City	
Ħ	permit. Pages Depertment of Important: If i any injury or Q059.		' 4 ☐ Donation 5 ☐ Other (Special Signature of Fur@ral Service Li	- A	Marylar			9/1/2005 Stewart F	Cheltenh	
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	ne deat the atte	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of death	3 ☐ Ectopic pregna 5 ☐ Other (specify			Month	Day Year
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			SOICON	CNO.	MD	Do	0552	5/14-	08-26-	2004
	5		30. Name and address of person w	no completed caus	e of death (Item 23a) (Ty	(pe, Print)	W DD	STE SON	7 Oron 1	tur m2074
	Sta	ate	31. Date filed (Month, Day, Year)	32. R	egistrar's Signature	· W	W 150	1210 20	I V V VVI	, 4-, 11/V
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			State of Maryland / Department of Health and M 1- State Registrar amend item #5 PER FH G847 9/24/10/5/24/9/06		ene = N2 1 1 5	20007
	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of Death Month		3. Time of Death
	/Media	al	MARY MARGARET BOOTH	09	11 05	11:17 AM
	Examin	er	4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital Cumberlan	d	ALL GO	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,) SEPT 23	9 Rint	nplace (State or Foreign untry) LAND
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	a-f sh	tor	MARYLAND ALLEGANY FROSTBURG			1 ☐ Yes 2 No
	vith the	Director	10e. Street and Number 10f. Zip Code	100	g. Citizen of What Co	untry?
	ns 23s	Funerai	10042 PINEY MOUNTAIN ROAD 21532 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	city Yes or No-	U.S.	ican Indian
036	d within 72 hours after death with the Maryland plane. I than "natural", or Items 23a or 28a-f show I'the Madical Examination to malified at	þ	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes ② □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto If Yes, Give Year or Dates:	Rican, etc.)	Black, White Specify:	
ιĠ.	"natur	Completed	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most of working life. DO NOT use retired)	ng 16	6b. Kind of Business/	ndustry
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	be filed tal Hygi d other avent, I	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name			
Maryland	should be nd Mental marked c	10	ROBERT RYAN MARGA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	RET EISE		in Code)
Ma	od 2 27 ls		JACKIE LEE BOOTH / HUSBAND 10042 PINEY MOUNTAIN R			
ore,	0 = 5		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	ate 20	Oc. Location - City or	Town, State
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Ba	permit. Departm Importa any inju		Hen yn Sowers moas 47 sowers funeral Home,	P.A. F	ROSTBURG,	MD 21532
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition)	r respiratory arres	t,	Approximate Interval Between Onset and Death
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	r At	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Stree City or Town, 1	et and Number or Rui State)	al Route Number,
	To the Hospitei or At within 24 hours after of To the Funeral Direct completely filled in by	edical (29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, a 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	nd due to the caused at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
	To the comp	Ň	29b. Signature and title of certifier 29c. License number		. Date signed (Month,	Day, Year)
,	n		Moura & Chypa MD D35135		4/11/0.	
	3		30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 140M45 & Cuapy // M) 9/250/EnD-Cu	m barlo	and MID	21502
	Sta	_	31. Date filed (Month, Day, Year) 52. Registrar's Signature		-/ //1	
	Registr	ar	SEP 1 4 2005 Regue to franker			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Terry Lee BOWARD August 31. 2005 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 14708 Falling Waters Road Williamsport Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov. 15,1957 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F 47 Yrs. Director 220-64-7141 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinar must be multiled at 10d. Inside City Limits Director 1 ☐ Yes 2 ▼ No Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14708 Falling Waters Road 21795 USA death by Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iten any Injury or other traumatic event, the Medical Examinat once. Black, White, etc. 1 Never Married 2KI Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 roll press operator tannery 0 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Rodney Dorothy Bowman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Boward - wife 14708 Falling Waters Rd., Williamsport, Md. 21795 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park 9/2/05 Hagerstown, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** 40mbr /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the attending physicien and hed for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1₽Yes 2□No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate Division of Vital 1 Yes 1 Yes 2 No 2 - No if or Attending Physician: after death. Director: After this certifica 25. Was case referred to médical examiner? Be 26. Place of Death (Check only one) Hospital: 1 🔲 Inpatient Other: 4 Nursing Home 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 TSuicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30 Name and address of person who c cause of dear (Item 23a) (Type, Print) 3H-2 ASC TIL rellie 11110 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes AMENDED, item10e1, State Registrar per F.H., TCHD, 09/01/2005, sbl. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** AUGUST 31 2005 1:35 AM CLARENCE EDWIN BARKER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner QUEEN STEVENSVILLE ANNE'S TERRAPIN GROVE, APT.320 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, SEPT 29 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days OHIO' 78 Director 300-18-5026 Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location 28e-f show the Medical Examinar must be notified at YYYYes 2 No Director QUEEN ANNE'S STEVENSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 TERRAPIN GROVE, APT. 320 21666 USA Items 23a by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. within 72 hours after 1 ☐ Yes 2 **X**No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 ö 1 ☐ Yes 2 XNo Specify. Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced "natural", 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) TEACHER ELEMENTARY EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Is marked of WILLIAM HENRY BARKER BESSIE BARKER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Health a 200 TERRAPIN GROVE, APT 320, STEVENSVILLE, MD 21666 MONIMIA BARKER/WIFE other Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ott FRIENDS OF THIRD HAVEN CEMETERY 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/3/2005 EASTON, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA OSTANUSKI CF. S.P Joseph 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or a certificate be executed ending physician and use as the burial-translt resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a o 9 Unknown 9 Unknown يم Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No 1 Yes 25. Was case reterred to medical examiner? 26. Place of Death (Check only Other: 4 Nursing Home Hospital: 2 2 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 ☐Other (Specify) escribe how injury occurred 28a. Date of Injury (Month, Day Year) . Manner of Death 28c. Injury at Work? 28b. Time of Certification: After 1 Natural 2 Accident 5 Pending investigation Injury death. 1 🗌 Yes 2 No the Director 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by or A efter 4 Homicide thin 24 hours e Hospite Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ş 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) 0

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

For

State of Maryland / Department of Health and Mental Hygiene 2005

29900

			Registrar			Cei	titicate	e of De	eath			Reg. No	- O		Em .	
	Physicia	an	Decedent's Name (First, Middle, La.								2. Date of D Month		ıy	Year	3. Time o	
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	Funeral		2201 Colston Dri 5. Social Security Number 6. S		Age (In yrs. i	last birthday)	If Under		Under 2	4 Hrs.	3. Date of B	irth				or Foreian
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	/land		10a. State 10b. County		10c. City	y, Town or Lo	cation							1	10d. Inside C	City Limits
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	or 28	Director	10e. Street and Number				10f. Zip	Code				10g. Ci	tizen of W	hat Cou	ntry?	."
	23a	ral	2201 Colston Driv	re, Apt.	910			20910				<u> </u>	. s.	Α.		
	Items Items	Funeral	11. Marital Status	12. Was Decede	es?	S. 13. \	Was Deced f Yes, spec	ent of Hispa ify Cuban, M	nic Orig Iexican,	in? (Spec Puerto R	ify Yes or Nican, etc.)	lo-		- Americ k, White,	etc.	
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D	filed v Hygie ther t		17. Father's Name (First, Middle, Last)			Dai	iquet			's Name (First, Middl					
Jan	Aental Aental rked o	To Be	Aaron Appel							y Cha				,		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show may ightry or other traumatic event, the Madical Examinet must be neitified at once.		19a. Informant's Name/Relationship (Samuel Braterman		ınd	19b. Mailin 2201	g Address Colst	(Street and ton Dr	Number ive	or Rural • Apt	Route Num. 910	ber, City o	orTown, s 1ver	State, Zip Spr	Code)	.d.
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Baltimore,	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service Licer	nsee)		£22	lward	d Address of Sage 1	Facility	heral	Dire	ctio	n, Ir	ıc.		
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•	D		30. Name and address of person who	completed cause	of death (Ita-	W /	Print	טט	315	J		Aug	ust 2	٠, ،	2005	
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			For State Registrar	State	of Ma	arylan		partme e <i>rtifica</i>				fental Hy	/giene		5	29	901
			1. Decedent's Name (First, Middle	, Last)								2. Date of D Month	eath Day	y Yes	ər	3. Time o	f Death
	.Physicia /Medic		Leon Joseph Bre	ton								August	27	200		8:00	P M
	Examin		4a. Facility Name (If not institution	_	number)					r Location	of Death		4c.	County of D	eath		
4			12230 Bare Bush						olum		O4 Uso			ward			-
	Funeral		5. Social Security Number	6. Sex 1 M 2 ☐ F			last birthda Yrs.	Month:	er 1 Year Days	If Under Hours	Min.	8. Date of Bi	ay, Year)				or Foreign
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	land ow		10a. State 10b. County			10c. Cit	y, Town or	Location							10	d. Inside C	ity Limits
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0 961	ig Physical this control direction	10	1 Yes 2 No 27. Manner of Death		Inpatie		ER/Outpa 28b. Time		28c. Inju	4 🗆 N	ursing Ho	ome 5 🔀 Res 28d. Describe		6 Other (S	pecify)		_
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Divisio	death death ctor: ,	fica	3 ☐ Suicide 6 ☐ Could	not be	ace of In	jury - At h	ome, farm,	street, facto				28f. Location			Rural	Route Nur	nber,
N N	after after Dire	Certification:	4 Homicide			tc. (Speci						City or Te	own, State	•)			
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the			ng Physician: To													
	n 24 he Fu he Fu	edical	(Check only 2 Medical one)	Examiner: On the and m	anner st		ation and/o	r investigatii	on, in my	opinion, de	ath occur	red at the time	, date and	d place, and o	Jue to 1	the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifie	" N	12	_		2		se number	70		29d. Da	te signed (Ma	onth, D	lay, Year)	
			1/201	4	U				DS	08	10		Au	gust 2	9,	2005	
			30. Name and address of person	-					C 7			MD 010	200				
			Dr. Susan K. A	1000 50C	S]	rar's Sign	Bell	. Ln.	Ста	rksvl	тте,	MD 210	129				
	Sta Registr		31. Date filed (Month Aug Ygar)	0 2005	The	rar's Signa	K,	ber	0								

		•	For State Registrar 1. Decedent's Name (First, Middle, I	State of Ma		Cer	tificate of	Death		Date of De	Reg. No.	_	29902
	Physici	an	Joseph Cosenz							Month	Day		
	/Medic		4a. Facility Name (If not institution, g				4b. City, Town, o	or Location o		epteml		1 2005 County of Death	
	Examin	eı	3114 Aldino F				Church					Harfor	ъ
	Funeral			Sex 7. Age	e (In yrs. las	t birthday)	If Under 1 Year Months Days			Date of Bir	th v. Year)		place (State or Foreign intry)
	Director		153-12-8346	1 ∑ M 2□F {	83	Yrs.	Monard Days	1100.0		Date of Bir (Month, Da 12/23	/1921	New	Jérsey
pue	*		Usual Residence of Decedent 10a. State 10b. County		10c. City, 7	Town or Lo	cation						10d. Inside City Limits
Aarvi	e sh	ō	MD Harfo	ord	Chur	chvil	le					}	1 ☐ Yes 2 ☐ No
6	288	Director	10e. Street and Number				10f. Zip Code				10g. Citi	zen of What Cou	intry?
with	23a or 28a-1 show		3114 Aldino E	Rd.			2102	28			τ	J.S.A.	
deat	itams 2	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S.	13. V	Vas Decedent of H Yes, specify Cuba	lispanic Orig	gin? (Specif	y Yes or No	>-	14. Race - Amer Black, White	
21215-0036 ad within 72 hours after death with the Mervland	rai', or itam	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced		WWII		☐ Yes 251 No					Specify:	ite
5-0	"natural",	Completed	15. Decedent's (Specify only highest of			16a. Deced (Give	ent's Usual Occup kind of work done OO NOT use retired	ation during most	t of working		16b. Kir	nd of Business/li	ndustry
121 with 10		du	Elementary/Secondary (0-12)	College (1-4or 5	i+)		.1 Servic				II C	Govern	ment
	ital Hyglene. Id other then avent, If e M.	ပိ	17. Father's Name (First, Middle, La	Ost)		CIVI	.I bervie		r's Name (F	irst, Middle			iiiciic
an	B C 2	To Be	Joseph Cosenz	a, Sr.				Patr	onella	a Pad	illa		
Maryland	and Menta is markad aumatic av	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street	and Numbe	er or Rural R	loute Numb	er, City or	r Town, State, Zi	ip Code)
	Health and Mentam 27 is marks		M. Adalee Cosenz	a (Spouse)			Aldino R		Church	nville	∍, MC	21028	
ore	or othar tr		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3	☐Removal from State	20b. Piac	e of Dispos letery, crem	sition (Name of natory or other plac		Date		20c. Lo	cation - City or T	own, State
ii m	ment tant: I	74	`4 □Donation 5 □ Other (Spe	cify)	R. A		ris & Co		/14/0			Cheste	r, PA
Baltimore,	Department of important: If i any injury or once.		21. Signature of Funeral Service Lic			22.	Name and Addre	ss of Facility Cargo	y Fune	cal Ho	ome,	P.A.	
	10 = 6 0		23a Part1. Enter the disease, or co	Zelma			Aberdeen					199	Approximate
J.			shock, or heart failure. List on Immediate Cause (Final	ly one cause on each lin	10.				04/3/40 01 11	sophatory a			Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death)	a Due to (or as a	a consequer		epsis						3 week
	xaminer				a consequer	100 017.							
		ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	Due to (or as	a consequer	nce of):		•					
V g	ician and burial-transit	Examiner	that initiated events	c.									
60, <	ian a	I Ex	resulting in death) Last	Due to (or as a	a consequer	nce of):							
68760,	physician the buria	edicai		d			<u> </u>						
	ට ග්		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnanc	у					2	3d. Date of deliv	verv
Вох	attendin	ciar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pregnancy Other (specify)	/				Month	Day Year
0	ad by the detached	Physician/M	9 Unknown	9□ Unknown									
ords, P.O. Box	ignad b	by P	Part II. Other significant conditions	_ 1		. /		ren in Part I.					the cause of death?
ord	been signatured to should to			Drabet				,		1 🗆 '	Yes 2]No 3∏Pro	bably 4 Unknown
9	2 S S	ompieted		Chronie	RE	enal	Fail	use		24a. Was auto	osy	prior to co	opsy findings available empletion of cause of
Vital Records,	ate pag	Con		Hyper	ten	sin					rmed? 2 No	death?	2 No
of Vita	certific rector.	Be	25. Was case referred to medical examiner?	Hospital:			Oth		of Death (C				
O a	this or	. To	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatie		VOutpatient Bb. Time of	3 □ DOA 28c. Injur			5 Resi		Other (Speci	fy)
	After funer	tion	1 Natural 5 Pending investigat	(Month, Day	Year)	Injury	Wor	k? Yes 2.⊟N			,-,		
Division	r death.	ifica	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of Inju		e, farm, stre	et, factory, office		28f.				al Route Number,
5	s after	Certification:	4 Homicide	building, etc	с. (Брөспу)					City or To	WII, State)		
	io na nospiral or Attairu within 24 hours after death. To tha Funaral Diractor: A completely filled in by the to	edical ((Check only 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner sta	examination	and/or inv	estigation, in my o	pinion, deat	th occurred	at the time,	date and	place, and due t	o the cause(s)
, F	withir To th	Me	29b. Signature and title of certifier	101021	10	1.0	29c. Licens	se number	44		29d. Date	signed (Month,	Day, Year)
•	,		11307	IVIIKCAF	1-13/	1100 1	10 2	1431	115			12-	
10	741		30. Name and address of person with 615, S. U.S.		eath (Item 2)	3a) (Type, 1	e de c	500	ce,	MI), :	2107	8
	Sta	_	31. Date filed (Month, Day, Year)	32. Registra	ar's Signatur	e L	(. v -						
	Registr	वा	3EP 1 4	E ZUUD DE	us s	1 14					-		

State of Maryland / Department of Health and Mental Hygiene 2005 29903 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death а **Physician** Gladys Ione Craig 28, August 2005 5:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Snow Hill Nursing & Rehab Center Snow Hill
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Worcester 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Months 89 256-03-2553 Director 8/27/1916 Oklahoma Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural," or Items 23e or 28e-f show any injury or other traumatic event. 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1X Yes 2 □ No Directo Maryland Worcester Snow Hill 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 430 W. Market St. 21863 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. ☐Yes 2XNo fYes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: Completed by Specify: white 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife 12 Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (unknown) Young Lula Lingerfelt 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Harrison/daughter 6495 Hickory Brook Rd., Chattanoga, TN 37421 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Springhill Memory 8/30/05 * 4 ☐ Donation 5 ☐ Other (Specify) Hebron, MD 22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804

Approximate of Juneral Service Licensee CFSP aure 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. WY201 Approximate Interval Between Onset and Death Immediate Cause (Final Physician tovaux disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. nding physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery the atten 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4 Pregnant at time of death 5 Other (specify) δ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has 2**2** No certificate 1 ☐ Yes Attanding Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🛣 No 2 this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Diractor: After 1. Natural 5 Pending 1 Tyes 2 No investigation death. 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital or within 24 hours 29a. Certifier LX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 2 8-28-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SARA() R. BARAL M.D., 1604.—Min 31. Date filed (Month 32. Agistrar's Signature State 0 2005 Registrar

The Contract of the Part of the Contract of Section 1 (1) and the Contract				For State	State	of Ma	ryland / Dep	artme	nt of H	lealth a	nd M	lental H	łygie	en20()5	29904
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2 (4) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAI A SEVANE MD 4703 QUEENS boug Pd Hyattsu; 4e MD 26787 State 31. Date filed (Month, Day, Year) AUG 2 6 2005	To the To the Comp	2	2	29b. Signature and title of certifier	1	.9	0	29	c. License	number			29d.	Date signed	(Month, L	Dey, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVI A Severe MD 4203 (Durews Gouy Rd Hyatts 6; 4e MD 2037) State 31. Date filed (Mopth, Day, Year) AUG 2 6 2005 AUG 2 6 2005				Onele	enell	1~	m	2	01	53	2		A	19457	22	2005
State 31. Date filed (Month, Day, Year) AUG 2 6 2005	2 (4)			30. Name and address of person of	who completed cau	Se of dea	ath (Item 23a) (Type	, Print) دور فر ها	Con	, Rd	Hu.	atter	~ II.	. MLA	2)47
				31. Date filed (Month, Day, Year) AUG 2 6 2	005	Registrar	's Signature		7000	7	· · L'	. 0100	744	- 7	•	7

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			Registrar 1. Decedent's Name (First, Middle	, Last)	1	Conmodit	0, 00	- Catiri		Date of Death	1		3. Time of Death
	Physici: /Medic		ANNEN	1. Cou	vley				1	Month ugust_	Day 26, 200	Year 05	12:45 a M
	Examin		4a. Facility Name (If not institution	, give street and number)			Town, or Lo				4c. County	of Death	
		Н	Holy Cross Ho 5. Social Security Number		je (In yrs. last birti		lver			Date of Birth	Monte		3
	Funeral Director		134-20-4374	1 M 2 M F	77	Months			Min.	Month, Day,	Year) 1928		plece (State or Foreign intry) York
	pu »		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Limits
	Aaryla f show	ō	Maryland Montg	omery		r Spring							1 ☐Yes 2 🛣 No
	28a-	Director	10e. Street and Number			10f. Zip				10	g. Citizen of V	What Cou	intry?
	23a o	ai D	14624 Silverst	one Drive		2	0905				US	A	
21215-0036	be filed within 72 hours after death with the Maryland that hygiene. do other than "natural", or Items 23a or 28a-f show event, the Madical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marria 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? ied 1 Yes 2 1 Yes, Give Year or Dates:	?	13. Was Deced	ify Cuban, I	anic Origir Mexican, F Specify:	n? (Specify Puerto Rica	Yes or No- in, etc.)	Blac	e - Ameri ck, White, : Whi	
2-0	72 ho	eted	15. Decedent (Specify only highes	('s Education at grade completed)	16a.	Decedent's Usua (Give kind of wor	k done duri	on ing most o	of working	1	6b. Kind of Bu	usiness/lr	ndustry
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Maryland	es 1 and 2 should be of Health and Mental f item 27 Is marked f other traumatic ev		19a. Informant's Name/Relations			Mailing Address							
45	and lealth m 27 her to		Robert E. Cow 20a. Method of Disposition	ley, Jr.	-	524 Silv Disposition (Nan		ne Di	rive,		r Sprin		
Baltimore,	permit. Pages 1 Department of H Important: If ite any Injury or ot		1 Burial 2 □ Cremation		cemeter	y, crematory or of Heaven C	ner place)	y	Augus	t 31			
ij	ortani Injury		* 4 □ Donation 5 □ Other (S _i 21. Signature of Funeral Service	_		22. Name an Francis	d Address o	of Facility	200				ing, Maryland
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			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each li	d the death. Do n	ot enter the mod	e of dying, s	such as ca	ardiac or re	spiratory arre	st,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Hyperka									1 Day
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of		H- 1	27. Manner of Death	28a. Date of Inju	ury 28b. T		8c. Injury at Work?				w injury occurr		197
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Division	or Attend after death Director: A	Certification;	3 Suicide 6 Could a determ	ined 289. Place of in	jury - At home, far tc. <i>(Specil</i> y)	rm, street, factory	office		281.	Location (Str City or Town,	eet and Numb State)	er or Rura	al Route Number,
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	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifie		7	290	. License n	umber		29	d. Date signed	d (Month,	Day, Year)
	8		reven	- Coning	wen_		D384	35			Augus	st 26	2005
_			30. Name and address of person Aaron Kenigsb	erg, M.D. 10	0313 Geoi	rgia Ave	nue,	#306,	, Silv	er Sp	ring, M	1D 2C	902
	. Sta Regist		31. Date liled (Month, Day, Year) AUG 3 0	2005 33 Registr	rar's Signature	parti							

State of Maryland / Department of Health and Mental Hygiene Reg. N2 005 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 9:25PM 23,2005 Μ. Croney August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville Montgomery Adventist Hospita Shady Grove If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month), Days Hours Min. May 30, 1947 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1□ M 2 🔀 F Months 362-48-1772 58 Michigian Director Usual Residence of Decedent filed within 72 hours after deeth with the Maryland Hygiene. 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ral', or items 23s or 28s-f show Examiner must be notified at 1. Yes 2 □ No Director MD Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29 N. Summit Ave 20877 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 "natural", or White 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) 2yrs Elementary/Secondary (0-12) Cashier Ammoco permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If Item 27 Is marked other tay injury or other traumatic event, there. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Goldie Moore 2 Bolt. Edward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29 N. Summit Ave Gaithersburg, MD 20877 Justin L. Clipper- Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/26/05 Metro Fnrl Svcs Alexandria, VA * 4 ☐Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Snowden Funeral Home, P.A. 21 Signature of Funeral Service License 246 N. Washington St Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ANOXIC ENCEPHALOPATHY weeks disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit the ettending physiclen and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2X No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à page 2 should be Ischemic Colitis Alcohol Dependence 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ZUnknown Be Completed Congestive Heart Failure Acute Panueatitis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 🗐 🐪 lo 1 ☐ Yes 2 ☐ **X**o 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{Specify} \) 1 Yes 2 No Certification; To 1 Propatient 2 ER/Outpatient 3 DOA ihis funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Hospital or Attanding 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No death. after death Director: 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MO D58681 August 24, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jude Alexander, MD 9801 Medical Center Drive Rockville, MD Registrar's Signature 31. Date filed (Month, Day, Year) 32 State AUG 30 2005 Registrar

			State of Maryland / Department of Heal State Registrer State of Maryland / Department of Heal Certificate of Dea	lth and Me <i>ath</i>	ental Hygie	ene 2005	29907
ľ	Physici	an	1. Decedent's Name (First, Middle, Last) David P. Coffin, Jr.		2. Date of Death Month 8/28/200		3. Time of Death
}	/Medio Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Local		3, 23, 233	4c. County of Death	
	Funeral		3112 Gracefield Road, Parkview #101 Silver Spr 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 1 If U Months Days Ho		B. Date of Birth (Month, Day, Y	Montgom	ery nplace (State or Foreign
0,	Director		264-07-0174		July 26,		rida
	aryland show	_	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	the M. 28a-f	Director	Maryland Montgomery Silver Spring 109. Street and Number 100. Zip Code		100	. Citizen of What Co	1 ☐ Yes 2 ☑ No untry?
	th with	al DI	3112 Gracefield Road, Parkview #101 20904			USA	
	ter dea Itams	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispani If Yes, specify Cuban, Me	nic Origin? (Spec exican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Amer Black, White	
21215-0036	permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked othar than "natural", or Itams 23a or 28a-f show amy ortant: If Item 27 is marked othar than "natural", or Itams 23a or 28a-f show any ortan in the motified at an once.	þ	31X Widowed 4 □ Divorced If Yes, Give 1942 1 □ Yes 2√2 No Special	pecify:		Specity: Wh:	ite
72-	in 72 ł	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	g most of working	7	b. Kind of Business/I	ndustry
2	led with lygiene har tha		4 Electronic Engin			rivate/Go	vernment
Maryland	ld be fil ental H ked otl Ic ever	To Be			First, Middle, Ma. Nickers		
lary	2 shou and M is mar is mar		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and N				ip Code)
e) S	1 and Health tem 27		Sharon Dwyer Daughter 9302 2nd Avenue 20a. Method of Disposition 20b. Place of Disposition (Name of	Silver	-	Maryland 2	
<u>m</u>	Pagas nent of ant: If It		1 □ Burial 2 ☑ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Crematory **Cometery, crematory or other place) Metropolitan Crematory	Δ110 20		lexandria,	200
Baltimore,	Departr Mports any inju		21. Signa, fe of Funeral Service Licensee 22. Name and Address of Francis J. Co	Facility 11ins Fi	meral H	ome. Inc.	
	434		23a. Part1. Enter the disease, or coplications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List of ly one cause on each line.	y Blvd.	W.,Silv	er Spring	Approximate
	rnysician		Immediate Cause (Final disease or condition Emphysema			1	Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of):				
	D if	iner	Sequentially list conditions, Thy bedfing to minude to cause. Enter Underlying Cause (Disease or injury)				OF WALK STANKS
,	axacute	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
8760,	cate be exacuted physician and the burial-transit	dlcal	d		-		
9	death certific e attending p id for use as 1	у/Мес	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliv	/en/
O. Box	ne death the atter hed for a	Physician/Me	in the past 12 months? 1			Month	Day Year
م	that the ed by detac	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in F	Part I.	23e. Did tobac	cco use contribute to	the cause of death?
ords	v requiras baen sign should be	ted b			1 🔀 Yes	2□No 3□Pro	bably 4 Unknown
Records,	e taw has b	Completed			24a. Was an autopsy performer	prior to co	opsy findings available ompletion of cause of
Vital	ician: Th certificate rector, pag	Be Co	25. Was case referred to medical 26.1	Place of Death (1 □ Yes 2 🔀 Check only опе)	No 1 Yes	2 □ No
of <	shys this al dii	ို		-		e 6 □Other (Spec	ify)
	ling After fune	atlon	27. Manner of Death 1 ★Natural 5 Pending 2 Accident Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 3 Work? M 1 ▼ Natural 5 Pending 28c. Injury at Work?		d. Describe how	injury occurred	
Division		Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28	f. Location (Stree City or Town, S	et and Number or Rui State)	ral Route Number,
_	To the Hospital or within 24 hours afte To the Funeral Dis completely filled in		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, da	ate and place, an	d due to the caus	se(s) and manner as	stated.
	To the He within 24 To the Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion and manner stated. 29b. Signature and title of official and manner stated.			and place, and due	
)			1 Colonill MA				
1	v * 1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1	Au	gust 29,20	כטע
	Sta	te	Roy Fried, M.D. 3110 Gracefield Road Silver	Spring,	<u>Marylan</u>	d 20904	
	Registi		31. Date filed (Month, Day, Year) AUG 3 0 2005 32)Registrar's Signature				

State of Maryland / Department of Health and Mental Hygiene 200529908 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 2005 Henry Carleton August 25, 6:27 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda 8. Date of Birth (Month, Day, Year) 9. Birthplace (Sta. Country) Nov. 29, 1914 New York If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1√2 M 2□ F 90 132-05-0344 Yrs Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State show 10d. Inside City Limits r 28a-f show Silver Spring Montgomery N☐Yes 2 No Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be 20906 U. S. A. 3310 N. Leisure World Blvd., # 628 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 5 1 Yes 2 No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Electrical Engineer Nassa other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any highty or other traumatic event size. Be Gitel Sluczak Isadore Kagan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Barbara L. Carleton - Wife 3310 N. Leisure World Blvd., # 628, Silver Spring 20c. Location - City or Town. State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State 8/28/2005 Olney, Maryland Judean Mem. Gardens * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Edward Sagel Funeral Direction, Inc. Cottlemuse 1091 Rockville Pike, Rockville, Maryland 23a. Part1. Enter the disease, or complications that caused the stath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Aspiration Onset and Death Provenoma Privoician /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 s autopsy performed? certificate 24 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification; To 1 Pinpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 2 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L 29a. Certifie 1 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 2005 10 170061307

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Records,

Vital

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32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

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31. Date filed (Month, Day,

ION COX		1 - For Unpend Item 23	State of Maryla a&27 per me	ind Depa 6847 Ger	artment of tificate o	Health and tas of Death			05 2990	1-0
Physici	an	Damion Cox					2. Date of Dea Month SEPT.	1, Day 2005	Year 1330 P	M
/Medic Examin		4a. Facility Name (If not institution, give str SOUTHERN MARYLAND			4b. City, Town	n, or Location of De		4c. County		
Funeral Director		Unknown	7. Age (In yr	's. last birthday) Yrs.	If Under 1 Ye Months Day			h v. Year)	9. Birthplace (State or Foreign Country) Montego Bayca	-
Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Md. Prince Geo		City, Town or Lo	cation Marlbor	0		al-shifty and	10d. Inside City Limit X□ Yes 2□ N	its
or 28	Oire	10e. Street and Number			10f. Zip Cod	е		10g. Citizen of W	/hat Country?	
a 23a	rai	4205 Duchess Cour				0772		Jamaio		
s 1 and 2 should be filed within 72 hours after deeth with the Maryland if Heeth and Mental Hygiene. If Heeth and Mental Hygiene. Item 27 is marked other then "natural", or items 23s or 28ss-f show other traumetic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 12 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	was Decedent of Yes, specify C		(Specify Yes or No- erto Rican, etc.)	Specify:	American Indian, k, White, etc.	
vithin 72 ho ne. hen "natur e Medical	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)		(Give life.	DO NOT use rei	ne during most of v	working	16b. Kind of Bu	siness/Industry	
Hygie Hygie ther ti nt, in		12th 17. Father's Name (First, Middle, Last)		Ch	ef	18 Mother's N	lame (First, Middle,	Restaur		
id be f ental } ked of ic eve	To Be	Philbert Roy Co	οx				ome Faulkr		9)	
nd 2 should is slith and Meni 27 is marked in traumetic	_	19a. Informant's Name/Relationship (Type Winsome Faulkner/Mc	e, Print)		-		Rural Route Numbe			
Pages 1 and 2 nent of Heelth int: if item 27 irry or other tra		20a. Method of Disposition 225 Surial 2 ☐ Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	p. Place of Dispo cemetery, crer cenwood	sition (Name of matory or other) Cem.	place) 9/1	Date 10/05		city or Town, State	
permit. Pages Department of I Important: If Ite eny injury or of		21. Signature of Funeral Service Licensee Aug W. 23a. Part1. Enter the disease, or complice	RIGH		H.S.Was	_	& Sons Co.	•	20019 N.E., Wash, D.	C
Priysician //Medical Examiner	dical Examiner	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Sickle Co Due to (or as a cons Due to (or as a cons	equence of):	ease				Inferval Between Onset and Death	
the death certificat by the ettending phy ached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	c. If yes, outcome of pred 1 □ Live birth 2 □ Fo 4 □ Pregnant at time o 9 □ Unknown	etal death 3□	Ectopic pregna Other (specify			23d. Date Mon	e of delivery tith Day Year	
w requires that the deall been signed by the etti should be detached for		Part II. Other significant conditions conti	ibuting to death but not r	resulting in the u	nderlying cause	given in Part I.	23e. Did to	./	ibute to the cause of death? 3 Probably 4 Unknow	v n
n: The law requires that the icete has been signed by the cage 2 should be detached.	Completed							osy p	Vere autopsy findings availab rior to completion of cause of eath? ☐ Yes 2☐ No	ole f
Physician: r this certifice ral director, p	o Be	25. Was case referred to medical examiner?	spitaf:	VTF010			Death Check only o			_
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.		1 XYes 2 No No 27. Manner of Death 1 ANatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ZER/Outpatier 28b. Time o Injury	f 28c. Ir	4 ☐ Nursing njury at Work? □ Yes 2 ☐ No	28d. Describe t	dence 6 ⊡Othe now injury occurre		-
tal or Atters after desail Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - Albuilding, etc. (Spe	t home, farm, str ecily)	eet, factory, offi	се	28f. Location (S City or Tov		er or Rural Route Number,	
Hospi 4 hou Funer ely fill	edicai	(Check only Wedical Examine	cian: To the best of my ker: On the basis of exam	cnowledge, deati	h occurred at the	e time, date and pla	ace, and due to the	cause(s) and mar	nner as stated.	Τ,
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in its	Med	29b. Signature and title of certifier	and manner stated.			ense number			(Month, Day, Year)	
F 3 F 8		Mayoute 1	re Soule	M	0.	.C.M.E		SEPT. 3	* * * * * * * * * * * * * * * * * * * *	
ge		30. Name and address of person who com	NO FILL	111 PEN		C, BALTIM	ORE MARYL	AND 2120	1	
Sta Regist		31. Date filed (Month, Day, Year) SEP 0 8 ZUUD	32. Registrar's Sig	hature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar 29910 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WICOM a If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex 1≜ M 2 ☐ F 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, 9-12-52 Birthplace (State or Foreign Country) **Funeral** Days Months Hours Yrs. Director 216-54-7582 52 Md. Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "naturat", or items 23a or 28a-f show edical Examiner must be notified at 1X Yes 2 No Delmar Wicomico Md. Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21875 USA 10720 Downs Way Funeral permit. Pages 1 and 2 should be filled within 72 hours after death Department of Health and Mental Hygiene. Important: If tem 27 is marked other the any injury or other traum—" 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Boat/Yacht Elementary/Secondary (0-12) College (1-4or 5+) Upholsterer Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Norma Mae Bozman Cugler 2 Harry Clarke Cugler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delmar, Md. 21875 10720 Downs Way, Jerrann Cugler, Wife 20a Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 8-27-05 Stephens Cem. Delmar, Del. `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home 13 E. Grove St. Delmar, De. 19940.
Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or our shock, or heart tarture. List only omplications that caused the death. Approximate Interval Between Onset and Dqatt Immediate Cause (Final Metastall Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signated 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No. certificete has b autopsy page perforq Yes the Hospital or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 1 Tes 1 Appatient 2 ER/Outpatient 3FT DOA 4 Nursing Home 5 Residence 6 Other (Specify) this After this funeral d Date of Injury (Month, Day Year) Certification: Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation ☐ Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours e To the Funerel C Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and une to the cause(s) and maining as saled.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b Signature and title 29d. Date signed (Month, Day, Year) 126278 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POBOX 1733 COASTAL HOSPICE DAND COLALL 31. Date filed (Month, Day, Year) AUG 2 6 2005

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Physician EURITH BERNICE CLOUGH AUGUST 17 2005 10:27 AM /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner GENESIS ELDERCARE SEVERNA PARK CENTER SEVERNA PARK ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dev. Year) Birthplece (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🕱 F Yrs Director 89 217-26-4586 JUNE 18, MD Usuel Residence of Decedent Peges 1 and 2 should be tiled within 72 hours after deeth with the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits mat be notified at 1 ☐ Yes 2 No Director MD HOWARD ELKRIDGE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7246 MONTGOMERY ROAD 21075 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0020 ò 1 ☐ Yes 2 No Specify: WHITE δ Specify: 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental I CLARENCE THOMPSON MARCELLA SEWELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Haalth item 27 VIRGIE L. COURSEY/DAUGHTER 7246 MONTGOMERY ROAD, ELKRIDGE, MD 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State ō 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) AUG. 21 STEVENSVILLE CEMETERY 2005 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician PNEUMONIA /Medical Immediate Cause (Final disease or condition Examiner resulting in death) PUCTIVE PULMONARY DISEASE Physician/Medical Examiner the burial-transit or Attending Physician: The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Division of Vital Records, P.O. Box 68760. that initiated events resulting in deeth) Lest Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yas 2 ☐ No þ 24b. Were autopsy findings available prior to Be Completed 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 2 140 this certificata 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient ursing Home 5 □ Residence 6 □ Other (Specify) To the Hospital or Attanding Physi within 24 hours eftar death.

To the Funeral Director: After this completely tilled in by tha funerel dir 3 DOA 27. Menner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated. 29a, Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 031/36

Registrar

31. Date filed (Month, Da

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KILBRIDE RD. BALTIMORE, und 21236

led cause of deeth (Item 23e) (Type, Print)

32 Registrer's Signature

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WALLACE

2005

		1 - State of Maryland / Depar State of Maryland / Depar Cert.	tment of Health and N ificate of Death	-	giene Reg. No 2005	29912
Physic	ian	Decedent's Name (First, Middle, Last)		2. Date of Dea	ath Day Year	3. Time of Death
/Medi	cal	PHYLLIS HUNTEMAN CROCKER 4a. Facility Name (If not institution, give street and number)	Ab Cir. Town I will at Don't	Hugust	- 22 2005	
Exami	ner	Memorial Hospital	4b. City, Town, or Location of Death	3	4c. County of Dea	I
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birti (Month, Da)		thplace (State or Foreign
Director		220-26-3311 1 M 2 X F 75 Yrs. Usual Residence of Decedent	World Days Hours Will.	JAN.15	1930 MAR	YLAND
/land		10a. State 10b. County 10c. City, Town or Loca	ation			10d. Inside City Limits
death with the Maryland ms 23e or 28a-f show Insust be redified at	tor	MD QUEEN ANNE CENTREVII	LLE			1 ☐ Yes 2 X No
ith the	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	puntry?
s 23e		805 CHURCH HILL ROAD	21617		USA	
tter de	Funerai	Armed Forces? If N	as Decedent of Hispanic Origin? (Sp res, specify Cuban, Mexican, Puerto	Pican, etc.)	14. Race - Ame Black, Whit	
hours after turei', or ite	b	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	∃Yes 2 No Specify:		Specify:	HITE
72 hc 72 hc	Completed	(Specify only highest grade completed) (Give kii	nt's Usual Occupation nd of work done during most of work	king	16b. Kind of Business	Industry
within 72 ene.	mpi	Elementary/Secondary (0-12) College (1-4or 5+)	NOT use retired)		OTH HOM	
Hygi ther int, I	a a	12 -0- HOMEMA 17. Father's Name (First, Middle, Last)		e (First, Middle,	OWN HOME Malden Sumame)	
	To B	EDWARD HUNTEMAN	BERTI	IA EBERH	ARD	
re, Maryiano s 1 and 2 should be f Health and Mental item 27 is marked o other treumatic eve		·	Address (Street and Number or Run BANTRY ROAD, EAST			Zip Code)
9 1 9 E 9		20a. Method of Disposition 20b. Place of Disposition		Date	20c. Location - City or	Town, State
altimor mit. Pages partment of portent: If it y injury or o				5-2005	QUEENSTOWN,	MD
permit. Pages: Department of himportent: If ite any injury or of once.		FEI	Name and Address of Facility LLOWS, HELFENBEIN BS. LIBERTY ST.,			
		23a. Part1. Enter the disease, or compfications that baused the death. Do not enter shock, or heart failure. List only one cause on each line.	the mode of dying, such as cardiac	or respiratory arr	est,	Approximate Interval Between
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certificate to ding physicals as the total	dicai	d	00(1)1 054	- 64-0-		
BOX OR Beath certific ettending p	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of defi	verv
he death the etter	Physician/Me		ctopic pregnancy Other (specify)		Month	Day Year
cords, F.O. wrequires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ecords law requires as been sign		LUNG CANCER		1	es 2 No 3 Pr	obabiy 4 🗀 Unknown
m 9 01	ompleted			24a. Was a		topsy findings available completion of cause of
ate Th	Con			perfor	med2 death? 2 No 1 ☐ Yes	
OI VITAL Physicien: This certifical rat director, p	Be	25. Was case referred to medical examiner?	26. Place of Deat	h (Check only or	10)	
7 = 4	7: To	27. Manner of Death 28a. Date of Injury 28b. Time of	3 DOA Other: 4 Nursing Ho		ence 6 Other (Spec	eify)
Attending r death. sctor: Alter by the fune	atio	1 X Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
or Attending after death. Director: After in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	t, factory, office	28f. Location (S. City or Town	treet and Number or Ru	ral Route Number,
urs af						
To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier (Check only one) (Check only one) (Check only one)	eccurred at the time, date and place, stigation, in my opinion, death occur	and due to the c red at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
To the within To the complete	Me	29b. Signature and title of certifier	29c. License number		9d. Date signed (Month	
6) // X	D48064	1	August =	73,2005
(Ans)		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri				
- 01	10	KEVIN STITELY, M.D., 505 DUTCHMAN'S I	ANE, EASTON, MD	21601		
Sta Regist		AUG 2 4 2005 Brown & Aug	alle .			

Amendese Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death AUGUST **JEREMY** BREWER CLARKE, 28 SR. 2005 4:00p 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 25271 Cheerful Echoes Lane Worton Kent | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec 20 19 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 🕅 M 2 🗆 F Yrs. 010-26-9728 70 1934 Massachusetts Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No MD Kent Worton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25271 Cheerful Echoes Lane 21678 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No 1954 If Yes, Give Year or Dates: -1956 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Business College (1-4or 5+) Elementary/Secondary (0-12) Marketing Director Machines 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Russell E. Clarke Louise M. Brewer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julee A. Clarke (daughter) 730 Ashepoint Way Alpharetta, GA. 30004 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 TCremation 3 ☐ Removal from State Kent Cremation 8/29/05 Smyrna, DE. *4 ☐ Donation 5 ☐ Other (Specify) 21. Sign pure of Funeral Service License Calena Funeral Home of Stephen L. Sc 21635 Schaech 118 West Cross St. Galena, MD. M00510 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) +dDue to (or as a consequence of) S unentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only prie) 20 No Hospital: Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide

Examiner The law requires that the death certificate be executed physician and s the burial-tran O. Box 68760. detached ಧಿಳ್ಳಿ of Vital Records, P. cate has been sig , page 2 should b certificate this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral

Examine Physician/Medical Completed by Certification: To Be Medical

Physician

/Medical

Examiner

Funeral

Director

rai", or items 23a or 28a-f show Examiner must be notified at

"natural"

Health item 27 I

permit. Pages Department of I Important: If its any injury or o

Physician

/Medical

Direct

Funeral

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Completed

with the Maryland

filed within 72 hours after death

Pages 1 and 2 should be

Baltimore, Maryland 21215-0036

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, State

4 - Homicide

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tive of perfities

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

D0051786

Andrew S. Ferguson, 120 Speer Rd. Chestertown, MD. M.D.

Day, Year 32. Redistrar's Signature AUG 2 9 2005

Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			1 – For State Registrar	State of Ma	aryland /		ent of Hea ate of De			ienez	005	29914
			Decedent's Name (First, Middle, La	st)					2. Date of Dea	th		3. Time of Death
	Physici: /Medic		HAROL	0	H.	Co	LEMI	9 N	Month August	Day 27	Year 2005	1032 M
	Examin		4a. Facility Name (If not institution, gir			4b. C	ity, Town, or Lo	cation of Deat	h		ounty of Death	
			CHESTER RIVE				C	HESTE	ERTO WN		KEN	7
	Funeral			Sex 7. Agu IDXM 2□F	e (In yrs. last b 83	Yrs. Month		Under 24 Hrs Hours Min.		Year)	Cou	olace (State or Foreign ntry)
	Director		Usual Residence of Decedent						11/24/	1921	M	ע
	yland how		10a. State 10b. County		10c. City, To	wn or Location						10d. Inside City Limits
	B Mar	ctor	MD QUEEN	ANNE'S	SUDLE	ERSVILLE						1 XYes 2 No
:	e 28	Director	10e. Street and Number			10f.	Zip Code		1	0g. Citize	n of What Cou	ntry?
	ath w		100 CHURCH CIR				2166			USA		
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. If Health and Sa or 28a-f show fether traumatic event, it a Medical Examinating the indifferd at	by Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces? 1 Yes 211			v	anic Origin? (S Mexican, Puerl <i>Specify:</i>	pecify Yes or No- o Rican, etc.)		. Race - Ameri Black, White, pecify: WH	
	hour tural	d be	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E	Year or Dates:	16	a. Decedent's U	rual Occupation		1	105 Kind	Lof Business/le	4
5	an" r	Completed	(Specify only highest gr	ade completed)		(Give kind of life. DO NO:	work done durir	ng most of wo	rking	16D. KING	of Business/In	dustry
212	s with jiene.	mo	Elementary/Secondary (0-12)	College (1-4or 5	i+)	MACHIN	E OPERA	ATOR		PRO	DUCTIO	N
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Mar	and 2 sho ealth and n 27 is ma		19a. Informant's Name/Relationship PAULINE COLEMAN		19	_			iral Route Number			Code)
ē,	s 1 and 2 if Health Item 27 other tra		20a. Method of Disposition		20b. Place	of Disposition (I	Vame of	1	Date	20c. Loca	tion - City or To	own, State
Ë	Page nent c int: If iry or		1 Burial 2 ☐ Cremation 3 (1 Donation 5 ☐ Other (Speci			ERSVILLE		9/1	/2005	SUDLI	ERSVILL	E, MD
Baltimore,	permit. Pages 1 s Department of He Important: If Item any injury or othe		21. Signature of Funeral Service Lice	nsee	. '	22. Name	and Address o	Facility F.L.FENB	EIN & NE	LINIΔM	FIINERA	I HOME
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	Physician /Medical		23a. Hart1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	a consequence	Ey A	pulse of dying, s	y A	or respiratory arr	est,		Approximate Interval Between Onset and Death
	The law requires that the death certificate be executed to the law requires that the last been signed by the attanding physician and bage 2 should be detached for use as the burial-transit.	dical Examiner	Secuentally list conditions: if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	a consequence							
89	tificat ig phy as thi											
O. Box	that the death certific ed by the attanding p detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea	th 3 Ectopic 5 Other	pregnancy (specify)			23	d. Date of delive Month	ery Day Year
P.O	res that tigned by	y Ph	Part II. Other significant conditions	contributing to death b	ut not resulting	in the underlyin	g cause given ir	n Part I.	23e. Did to	pacco use	contribute to the	ne cause of death?
rds,	quires n sign ald be	d b	Revenuo	NIA					1 🗆 Y	s 2 🗖	No 3□Prot	ably 4 Unknown
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ta		0	25. Was case referred to medical				26	6. Place of Dea	th Check on on		1 🗆 1 63	215,1110
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0	ding Pi After ti funera		27. Manner of Death 1 ⊠Natural 5 ☐ Pending	28a. Date of Inju (Month, Day	y Year) 28b	Time of Injury	28c. Injury at Work?		28d. Describe ho	w injury o	occurred	
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Division of Vital Record	tal or Attenors efter death al Director: ed in by the	Certification;	4 Homicide determined		ury - At home, c. (Specify)	farm, street, fact	ory, office		28f. Location (St City or Town	reet and I n, State)	Vumber or Rura	il Route Number,
	To the Hospital or within 24 hours efte To the Funeral Dir. completely filled in the completely	edical	29a. Certifier 1 Certifying P (Check only one) 1 Medical Exe	nysician: To the best of miner: On the basis of and manner sta	examination a	ge, death occurre and/or investigati	ed at the time, on, in my opinion	date and place on, death occu	, and due to the carred at the time, d	ause(s) ar ate and pl	nd manner as s lace, and due to	tated. o the cause(s)
	To the within 2. To the I complet	Me	29b. Signature and title of certifier	-		2	29c. License nu	ımber	C1 2	9d. Date s	signed (Month,	Day, Year)
			Mullion	Szan	~		100	e+8	7	8/	Q7.	105
			30. Name and address of person who WILLIAM TRAINE	completed cause of d	eath (Item 23a) (Type, Print) CHESTER	TOWN. M	m 2162	0			
			31. Date filed (Month, Day, Year)		ar's Signature	JIIIO I III			-			
	. Sta Registr			2005	Z. o Olgridition	Acer	20					

		1 - For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of F rtificate of	lealth and <i>Death</i>		ene2005	29915
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Funeral		5. Social Security Number		(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs		9. Birt	hplace (State or Foreign
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pug 🚵 👊		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or Lo	cation				10d. Inside City Limits
Maryland -f show	5		ester	100. Only, Town of Ed					1 ☐ Yes 2 XNo
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3a or	ā	5005 Maple Da	m Road			1613	100	USA	unity:
Z ta garage	Funeral Director	11. Marital Status	12. Was Decedent 8	Ever in U.S. 13. V	Was Decedent of H		Specify Yes or No-	14. Race - Ame	
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should be filed within 72 hours after death with the Marylan at Mantal Hygiene. marked other than "natural", or items 23a or 28a-f show imatic event, the Madical Examiner must be multimed at	d by	3 Widowed 4 Divorced	Year or Dates:					Specify: W	hite
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2 should I and Meni is marke	-	19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Mailin	ng Address (Street			City or Town, State, 2	Tip Code)
is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. It was 1 secured than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at		Ernest Christop	her Jr. hus	sband 5005	Maple D	am Road.	Cambridge	. MO 216	13
of He or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		20b. Place of Dispo- cemetery, cren	sition (Name of natory or other plac	ce)	Date 20	c. Location - City or	Town, State
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law r les be	Completed						24a. Was an autopsy		topsy findings available completion of cause of
The cate h	Cou						performe	d? death? INo 1 ☐ Yes	25 Mo
ysician: The law ysician: The law is certificate hes b director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		Oth		ath Check on one		
Phys this	2	1 Yes 2 No 27. Manner of Death	28a. Date of Injur			4 🗀 Nursing r	lome 5 Residence 28d. Describe how	De 6 ☐Other (Spec	sify)
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Attan r dea actor	ifica	3 Suicide 6 Could not determine	ot be 28e. Place of Inju	ry - At home, farm, stre	et, factory, office		28f. Location (Stre	et and Number or Ru	ral Route Number,
s afte	Certification;	4 Hornicide	building, etc	. (Ѕреспу)			City or Town,	State)	
To the Hospital or Attanding Physician: The law requires that the death certification at the Hospital or Attanding Physician: The law requires that the death. To the Funeral Diractor: After this certificate hes been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier Chack only one) Certifying 2 Medical E	Physician: To the best of xaminer: On the basis of and manner sta	examination and/or inv	occurred at the tin restigation, in my o	ne, date and place pinion, death occu	e, and due to the cau irred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier	Thuy		29c. Licenso			. Date signed (Month	* '
		1 air	MD MD		104	7924	4	8.28.0	5
		30. Name and address of person w			Print)	10	-	2 (
		31. Date filed (Month, Day, Year)		TVRJRA C	CATA!	KRIDGE	MD	1/6/3	
Sta Regist		AUG	3 0 2005	See A	Cooks				

CHRISTOPHER, ELIZABETH

		1 - State of Maryla Registrar		rtificate of L		R	eg. No.	005 29	916
Physic	ian	1. Decedent's Name (First, Middle, Last)				2. Date of Deal	Day	3. Time of [Death
/Medi Exami		ROBERT GREENE DOLAN 4a. Facility Name (If not institution, give street and number)		4b. City. Town. or	Location of Death	rtugus (ty of Death	141
Exami	ilei	Peninsula Regional Medicas Co	onter	Sal	isbury			inico	
uneral		5. Social Security Number 6. Sex 7. Age (In yr	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		Birthplace (State or Country)	Foreign
Director		044-24-7483	Yrs.		12.0	FEB.26,		NEW HAVEN,	
WOL			City, Town or Lo	ocation				10d. Inside City	/ Limits
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or itama 23a or 28a-1 show o it et must be notified at	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of	What Country?	
na 236	by Funerai	616 SPRING LAKE DRIVE 11. Marital Status 12. Was Decedent Ever in	US 13 1	19930		ecify Ves or No-	USA 14 Ra	ace - American Indian,	
ritan	E	1 Never Married 2 Married 1 1 7 9 2 1 No	'	Was Decedent of Hi If Yes, specify Cuba		Rican, etc.)		ack, White, etc.	
E Mail	l by	3 Widowed 4 Divorced If thes, Give Year or Dates 1951	-1955	1 ☐ Yes 2X No	Specify:		Speci	ify: WHITE	
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than re M	dmc	Elementary/Secondary (0-12) College (1-4or 5+)		MINISTRAT			II.S.GO	VERNMENT	
evant, 1	Be C	17. Father's Name (First, Middle, Last)	1110	IINIDIMI	18. Mother's Name				
s marked o umatic eva	ToB	JOHN DOLAN			ELIZABE	TH GREE	NE		
emne.		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a	and Number or Rura	al Route Number	, City or Town	n, State, Zip Code)	
Itam 27 other tr		DARLENE A. DOLAN / WIFE 20a. Method of Disposition 20b	616 Place of Dispo	SPRING LA	KE DRIVE,	BETHAN	Y BEAC	H, DE 19930 - City or Town, State	
		1 Burial 2 □ Cremation 3 □ Removal from State	ELAWARE	"VETERANS	9)	-10			
Important: I any Injury o once.		'4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses M00866	CEMETERY 22			/2005			
important: If it any injury or o		Agith Its sell		ARSELL FU				IUM 1997 CLARKSVILLE,	'0 DE
		23a. Parti. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.	ath. Do not ent	er the mode of dying	g, such as cardiac o	or respiratory arr	est,	Approximate Interval Betw	
ysician	ŀ	Immediate Cause (Final disease or condition	D					Onset and De	eath
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ansit	Examiner	if any, Taxining to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		-					
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for us	clan	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 Live birth 2 Fe	etal death 3	Ectopic pregnancy Other (specify)			1	ate of delivery Ionth Day Ye	ear ear
tached	ysid	1 Yes 2 No 9 Unknown 9 Unknown							
pe det	by Pl	Part II. Other significant conditions contributing to death but not r	esulting in the u	nderlying cause give	n in Part I.	23e. Did to	oacco use cor	ntribute to the cause of de	ath?
should	eted					1 □ Ye	os 2□No	3 ☐ Probably 4 M Ur	nknown
0 01	ompie					24a. Was a autops	y	. Were autopsy findings at prior to completion of car	vailable use of
cale .	S					perform 1 Tes 2		death? 1 ☐ Yes 2 ☐ No	
rector	o Be	25. Was case referred to medical examiner? Hospital: Hospital:	E-500	Othe	26. Place of Death				0.7
ar this certificate has eral director, page 2	\vdash	27. Manner of Death 28a, Date of Injury	☐ ER/Outpatier 28b. Time of	IL 3 DOA	4 Nursing Ho	me 5 ∐ Reside 28d. Describe ho			
r: After the funeral	atio	1 K Natural 5 ☐ Pending (Month, Ďaý Year) 2 ☐ Accident investigation	lnjury		:? /es 2 □ No				
by th	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - All building, etc. (Special Coulding)	t home, farm, str	reet, factory, office	9	28f. Location (St City or Town		nber or Rural Route Numb	er.
led in									
completely filled in by the fu	Medicai	29a. Certifier 1	nowledge, deatl ination and/or in	h occurred at the tim vestigation, in my op	e, date and place, a pinion, death occurr	and due to the ca ed at the time, d	ause(s) and mate and place	nanner as stated. , and due to the cause(s)	
omple	Me	29b. Signature and title of certifier		29c. License	number	2	9d. Date sign	ed (Month, Day, Year)	
0			~6	1400	5741	0	8/2	6/05	
y		30. Name and address of person who completed cause of death (II	tem 23a) (Type,	Print)	5741. bury,	-	1-	1	
5		Simona Eng 100 E. Carr	011 St	Salis	bury,	MD c	21801	/	
	tate trar	31. Date filed (Month, Day, Year) AUG 3 0 2005 32. Registrar's Sig	gnature		711		<u> </u>		

			For State Registrar	State of	Maryland	l / Depa <i>Cei</i>	artment rtificate	of H	ealth a Death	ind M	ental Hyg	iene,	2005	29	917
П	Physicia		Decedent's Name (First, Middle								2. Date of Dear Month		, 2005	3. Time of	
	/Medic	al	Mary Frances 4a. Facility Name (If not institution				4h City To	own or	Location o		August		, ZUU5 County of Death	7:37	a [™]
	Examin	Ç.	Bayside Care		,,		4b. City, Town, or Location of Death Lexington Park						. Mary		
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. la	st birthday)	If Under 1		If Under 2	24 Hrs	8. Date of Birth	Date of Birth 9. Birthplace (Month, Day, Year) Country)			or Foreign
	Director		219-42-3651	1□M 2XF	89	Yrs.	WOTETS	Days	riodis		Aug. 25,	1916	5 Virg		
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation						1	0d. Inside C	ity Limits
	Mary	ţo	Maryland Charl	es	Indi	an He	ad							1 XYes	2□No
	or 28	Oire	10e. Street and Number				10f. Zip C				1		en of What Cour	itry?	
	s 23a	rail	11 Delta Place	12. Was Decede		10.1		0640		-i-2 (0	-7		S.A.	an Indian	
' 0	fter de r Itam Ir er r	Funeral Director	11. Marital Status1 ☐ Never Married 2 ☐ Marr	Armed Force	es?				n, Mexican	, Puerto	ecify Yes or No- Rican, etc.)	'	Black, White,		
21215-0036	within 72 hours after deeth with the Maryland ene. Itan "natural", or itams 23a or 28a-f show he Madical Examinar main be notified at		3 Widowed 4 □ Divorced	ied 1 Tes 2 If Yes, Give Year or Date	9S:		1□Yes 2l	L X No	Specify:				Specify: Whi	te	
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ם 2	e filed Il Hygl other	Be Co	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name	(First, Middle,				
ylar	should be nd Mental marked o	ToE	Francis Neal Ca	ry							Saffel				
Maryland	and e m		19a. Informant's Name/Relations Jane Bussey	hip (Type, Print) Daughter							Naldorf,		Town, State, Zip	Code)	
di.	ss 1 and 2 of Health item 27 i		20a. Method of Disposition						-	-	ate		ation - City or To	wn, State	
m _o	Pages nent of tnt: if i		1 Surial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		Trin	nity M	osition (Name matory or oth lemoria	al G	"Aug arder	is ²⁹ ,	2005	aldo	orf, Mar	yland	
Baltimore,	permit. Pages 1 Department of H Important: if ite any njury or ot		21. Signature of Funeral Service				2. Name and			-					
	g02 g g		23a. Part 1. Enter the disease, or	llu	M00668	4	270 Ha	awth	orne	Rd.,	ome, P.A Indian	Hea	ad, Md.	20640 Approximat	
			shock, or heart failure. List	only one cause on ea	n ine.	DO HOT GIT	The iniode	or dying	g, such as	Carriac	ir respiratory arr	θSι,		Interval Bet Onset an	ween
	Pnysician /Medical		disease or condition resulting in death)	aDue to los	ra a conseque	ence of):	nong	1	ar	W)	ve		-	WYS	4
	Examiner		Sequentially list conditions.	b	nd st	age	5	0.1	O.Pa	D,				42	
	led lst	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	r as a conseque	ence of)	1
,	execut n and ial-trar	Examine	that initiated events resulting in death) Last	cDue to (or	r as a conseque	ence of):									
8760	death certificate be executed e ettending physician and nd for use as the burial-transit	edicai		L d											
9	ertifica ling ph	Med	IF FEMALE:	220 16 100 01101								- 1			
Вох	eath certific ettending p for use as 1	Physician/M	23b. Was decedent pregnant in the past 12 months?		th 2 ∐ Fetal∈ ntattime of de	death 3[Ectopic pred					2	3d. Date of delive Month	*	Year
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S, D	The law requires that the tee has been signed by thoage 2 should be detache	by P	Part II. Other significant condition	ons contributing to dea	th but not resul	lting in the u	ınderlying cau	use give	n in Part I.		23e. Did to	bacco us	se contribute to the		
ord	w requir been si should										1 U Y	es 2	JNo 3□Prob	pably 4 🖭	Unknown
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ta		e Co	25. Was case referred to medica						26 Place	of Doath	1 Yes	2. No	1 Yes	2 No	
	ysic is ce direc	0 8	examiner?	Hospital:	patient 2 E	ER/Outpatier	nt 3□ DOA	Othe			n <i>(Check only or</i> me 5 ☐ Reside		Other (Specific	v)	
n of		T :uo	27. Manner of Death 1 Natural 5 Pendir	28a. Date of (Month,	Injury , Day Year)	28b. Time o Injury	of 28	c. Injury Work	at		28d. Describe h	ow injury	occurred		
Division	at sat	cati	2 Accident investi	gation not be	/ 1		М		res 2□!	-	OBS Lanation (C	4	t himman a a China	-/ Courte More	
Divi	after of Direct of in by	Certification;	determined 288. Place of Injury - At nome, farm, street, factory, office 201. L								City or Town		i Number or Rura	I HOULE NUM	iber,
	To the Hospital or Attu within 24 hours after de To the Funeral Directo completely filled in by ti		29a. Certifier 1 Certifyir (Check only 2 Medical	ng Physician: To the b	est of my know	vledge, deat	death occurred at the time, date and place, and due to the cause(s) and manner as stated. Wor investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
	the H hin 24 the F nplete	Medical	one)	and manne	stated.	ori ariu/or iri									•)
	7 × 10 × 10 × 10 × 10 × 10 × 10 × 10 × 1	-	29b. Signature and title of certifie	mart 1	4/2	ALI	7	Cense	number	419			signed (Month,		-
Λ			30. Name and address of person	who completed cause	of death (Item	23a) (Type	Print)) (10	111		0	90		
1	85		James P. Jarbo	e, M.D., /	24035 T	hree	Notch	Rd.	, Hol	lywc	od, Md.	206	36		
	Sta Regist		31. Date filed (Month, Day, Year)	9 2005	strar's Signati	ure /	Sperke	,							

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2005 29918 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month Yaar DIETZ 5:20 AM MARIETTE AUGUST 28 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner John Hopkins Bay View Medical Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) 9. Birthplace (State or Foreign Country) Sept. 19,1943 Washington DC **Funeral** Days Hours 1 □ M 2 □XF 577-58-2178 61 Director Usuat Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits iral, or items 23s or 28s-f show Examiner must be mutitled at 1 X Yes 2 No Directo Washington D. C. e L 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 2471 Alabama Ave., S.E. U.S.A. 20020 Funerai Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Maritat Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ White 3 ₩Widowed 4 Divorced Year or Dates: 'natural' Completed d other than "natur event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) al Hygiene. Administrative Assistant Institute 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be 1 nent of Health and Mental I if Health and Menta Robert Kemp, Sr. Mary Helen Newman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georgette K. Brown Sister 2211 Garden Lane, Bryans Road, Md. 20616 20b. Place of Disposition (Name of commetery, crematory or other place) Aug. 29, 2005

Metropolitan Funeral Service Alexandria, Va. 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Şervjce License Williams Funeral Home, P.A. 20640 Md. M00668 4270 Hawthorne Rd., Indian Head, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in fail ire. List only one cause on each line. tmmediate Caus (Fin I HYPERCARBIC RESPIRATORY FAILURE **Physician** 24 hours resulting in death) /Medical Due to (or as a consequence of): Examiner PNEUMONIA WEEK Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed 2 WEEKS SEPSIS that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy jo Year Dav 4☐Pregnant at time of death 5 Other (specify) P.O. ☐Yes 2 No detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ CORONARY AFTERY DISEASE 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably peeu MORBID OBESITY 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Certification; To Be 26. Place of Death (Check only one) Hospital: 1 npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25(No 2 ER/Outpatient 3 DOA this in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a To the Funeral L To the Hospital pelij 29a. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 000 AUGUST 28 2005 MP 30. Name and address of passon who completed cause of death (Item 23a) (Type, Print) BALTIMORE MARYLAND 2128+ 600 NORTH WOLFE AHON KHAI STREET AIMA 31. Date filed (Month, Day, Year) 32. Refistrar's Signature State AUG 3 0 2005 Registrar

		State of Maryland / Department / Department / Departm	ent of Health and Nate of Death	Mental Hygiel	000=	20010
Physici /Medi		Decedent's Name (First, Middle, Last) June Lyllis Damon		2. Date of Death	Day Year	3. Time or Death 7:55 A M
Examir			ty, Town, or Location of Death		4c. County of Death	
Comment			Waldorf der1Year If Under24 Hrs.	8. Date of Birth	Charles	
Funeral Director		578-52-6272		Sept. 20,	9. Birthp Cour 1917Washi	ngton DC
yland		10a. State 10b. County 10c. City, Town or Location				0d. Inside City Limits
Ba-f s	Director	Maryland Charles Waldorf	·			1 ☐ Yes 2X No
with the as or 2	Dire	106. Street and Number 4140 Old Washington Road	Zip Code 20602	10g.	Citizen of What Cour	ntry?
death ma 23	Funeral		cedent of Hispanic Origin? (Sp pecify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Americ	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dependarment of Heath and Mental Hygiene. Important: If them 27 is marked other than "natural; or items 23s or 28s-f show any injury or other traumatic event, the Medical Examination at Le motified at once.		1 Never Married 2 Married 1 TYes 2 TXNo	No Specify:	Hican, etc.)	Black, White,	White
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2121 d within giene.	Completed by	Flementany/Secondary (0-12) College (1-4or 5+) life. DO NOT	rd Operator		ommunicat	ions
land ild be file ental Hy ked oth	To Be (17. Father's Name (First, Middle, Last) Ernest Davis		e (First, Middle, Maid Brown	len Sumame)	
Baltimore, Maryland 21215-0036 semit. Pages 1 and 2 should be filed within 72 hours all Department of Health and Mental Hygiene. Important: It item 27 is marked other than "natural; or any Injury or other traumatic event, the Madical Examples.	-		ess (Street and Number or Rui			Code)
ore, of Heal of Heal		20a. Method of Disposition 1 M Burial 2 Commetter, 3 Demoyal from State	lame of rother place)	Date 20c.	Location - City or To	wn, State
ti. Pag rtment rtant: njury c		`4 ☐Donation 5 □ Other (Specify) Cedar Hill C	Cemetery 8-30	_	tland, MD	
Bal permi Depa impo any Ir		1101051	and Address of Facility t Funeral Home		Box 156 cf, MD 206	04
Physician		23a. Part1. Inter the disease, or complications that caused the death. Do not enter the m shock, or heart failure. List only one cause on each line.	ode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
/Medical Examiner		disease or condition resulting in death) Due to (or as a consequence of):	INWA			
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)				
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certific	/Med	IF FEMALE: 23b. Was decaded proceed: 23c. If yes, outcome of pregnancy			22d Data of deliver	-
death death defor u	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 25c. I yes, ottoched pregnant 3			23d. Date of delive Month	ny Day Year
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cords, P w requires that been signed t should be deta	ted	- Bretta		1 🗆 Yes	2 Prob	ably 4 Unknown
I Rec The law ate hes b	Completed			24a. Was an autopsy performed:	prior to con death?	osy findings available npletion of cause of 2 No
Vital F sician: The certificate rector, pag	BeC	25. Was case referred medical examiner?		h Check on one		2010
Of Phy rathis	- T	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ I 27. Manner of Death 28a. Date of Injury 28b. Time of		me 5 Residence)
	ation	1	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	200. 2000. 20 110 11 11	quiy cocuired	
	ertification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	ory, office	28f. Location (Street City or Town, Sta	and Number or Rural ate)	Route Number,
Hospita 4 hours Funeral	edical C	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred and manner stated.	ed at the time, date and place, on, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as stand place, and due to	ated. the cause(s)
To the P within 24 To the Complete	Med	and marrier states.	9c. License number		Date signed (Month, L	Day, Year)
. 21. 0		Men a feather, min	00021031	8	126/05	
Sb7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Michael A. Leatherwood, 12070 Old Lir	ne Center, Sui			20602
C+	ate	31. Date filed (Month, Day, Year) AUG 3 0 2005 32. Registrar's Signature		· · · · · · · · · · · · · · · · · · ·		

<u>.</u>		Registrar 1. Decedent's Name (First, Middle, Last)	State of Marylan per 111, 6848				2. Date of De Month		Year	3. Time of Death
ysicia Iedica		Jeanne Warwic	k Dunlop				AUGUST	20	2005	4:40 P
amine	_	4a. Facility Name (If not institution, give				Location of Death		4c. Co	unty of Death	_
		Calvert Manor Heal 5. Social Security Number 6.			R1s	sing Sun	8 Date of Bir	th	Ceci	
eral ctor			37	85 Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da 07/14/1	y, Year) 1 920		lace (State or Foreity) er, PA
		Usual Residence of Decedent 10a, State 10b, County	10c. Cit	y, Town or Loc	ation				1	0d. Inside City Lin
D D	.	Maryland Cecil		North	East, Ma	rvland				1 ☐ Yes 2 🖔
a a	S F	10e. Street and Number			10f. Zip Code			10g. Citizer	of What Cour	ntry?
20		7 Lower Beach Dr	ive		2	21901			USA	
1	by Fur	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ≦ No If Yes, Give Year or Dates:	lf	Vas Decedent of H Yes, specify Cuba ☐ Yes 2X No	ispanic Origin? (St in, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		Race - Americ Black, White, pecify: Wh	
lical	Completed	15. Decedent's Edu (Specify only highest grad		(Give I	ent's Usual Occup	during most of worl	king	16b. Kind	of Business/In	dustry
a Me	dm	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	NOT use retired Homema	_			Own H	OMA
July I	ပ္	17. Father's Name (First, Middle, Last)			пошеша	18. Mother's Nam	ne (First, Middle	, Maiden Su		One
ic eva	To Be	James Robert Cam	neron				d Warwi			
umat	-	19a. Informant's Name/Relationship (7)	rpe, Print)	19b. Mailing	g Address (Street	and Number or Ru	rai Route Numb	er, City or To	own, State, Zip	Code)
ser tre		William Dunlop - H				Drive -				
or oth		20a. Method of Disposition **Burial 2 Cremation 3 DF	Communiferan State		atory or other place		Date		ion - City or To	
jury		* 4 ☐ Donation 5 ☐ Other (Specify)	Not	th Eas	t Method Cemetery	ist Augus	st 27, 2005	Nort	h East,	Maryla
any in		21. Signature OF Funery Service Lignens	rel	1		Main St	reet, No	orth E	uneral ast, Ma	aryland
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cian lical		disease or condition resulting in death)	DEMENTA-		mer 14)ह				
iner			Due to (or as a conseq	juence of):						
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the burial-transit	EX	resulting in death) Last	Due to (or as a conseq	juence of):					To the state of th	
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99	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 SNo 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	ıl death 3□	Ectopic pregnancy Other (specify)			23d	I. Date of delive Month	ary Day Year
be detac	by Ph	Part II. Other significant conditions co	ntributing to death but not res	sulting in the un	iderlying cause giv	en in Part I.	23e. Did 1	obacco use	contribute to the	ne cause of death
should be	q pa	Hyprotenton					10	Yes 2□N	lo 3 ☐ Prot	abiy 4 Unkr
2 sho	Completed						24a. Was			psy findings avail mpletion of cause
page 2	Com						perfo	omed?	death?	2□ No
0	Be	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only	one)		
ਰ	2	1 ☐ Yes 2X No		ER/Outpatient		4 Nursing H	ome 5 Resi			y)
191	tion	27. Manner of Death 1. Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor M 1	yat k? Yes 2 □No	28d. Describe	now injury o	CCUII 0 G	
چ	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h						lumber or Rura	il Route Number,
y the fur	erti	4 Homicide determined	building, etc. (Specif				City or To	wn, State)		
od in by the fur	100	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
letely filled in by the fur		one)	and manner stated.		200 1:	e number		29d. Date s	igned (Month,	Day Vearl
completely filled in by the funeral	Medical C	29b. Signature and vittle of certifier					1		•	Day, rear/
completely filled in by the fur	edical	one)	>		H58			Augus	T 25, 207	
completely filled in by the fur	edical	one)	ompleted cause of death (ligh	n 23a) (Type, I	H58		17to 11	Augus		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2005 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician Year Wilma Veronica Dyson August 25, 2005 10:25 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year)
Dec. 7, 1932 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🕅 F 72 Yrs 156-24-5685 Director New Jersey Usual Residence of Decedent the Marylend 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23e or 28e-f show the Medical Examinar must be notified at **X**Yes 2 □ No Director D.C. N/A Washington 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? with #108 3701 13th Street, Funeral N.W. 20010 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours efter 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2€ No Specify: Specify: **Black** Completed by 3 Widowed 4 XDivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 2 Registered Nurse Medical permit. Pages 1 and 2 should be file Deperment of Health and Mental Hy Importent: If item 27 is marked oth any follury or other treumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Victor Patterson Ophelia Love 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Dyson 7630 Southern Oak Drive, Springfield, VA (Daughter) 22153 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 9/2/05 Chesapeake Crematory * 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland 22. Name and Address of Facilit McGuire Funeral Service 21. Signatur o Funeral/Service Licenses 7400 Georgia Ave. N.W., Washington, D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis Syndrome /Medical Due to (or as a consequence of): Examiner Bilateral Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dualto (or as a consequence of): physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical attending f IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 Tyes 2 XVo Month Day Year 4 Pregnant at time of death 5 Other (specify) Records, P.O. the detached 9 Unknown 9 Unknown ፩ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Urinary tract infection, Diabetes Mellitus 1 Tes 2XXNo 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Hypertension, End Stage Renal Disease has autopsy performed? 1 ☐ Yes 21 No Division of Vital Hypercalcemia, Hyperparathyroid, Backache Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Nonpatient 2 ☐ ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2X No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 X Natural efter death. Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide e Funerei Dietely filled in 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical npletely (Check only one) and manner stated To the P within 24 To the F 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number suyamtus D53367 10 August 26, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R. Shyam Sundar, M.D. 10810 Darnesdown Road Suite 202, Gaithersburg, MD 20878 31. Date filed (Month, Day, Year) 32. Registrar's Signature 29 marke AUG 2005 Registrar

			For 1 - State Registrar	cuoc			nd / Depa		t of H	ealth a		ental Hygi	ene _	005	29922
	Physici /Medio Examir	al	Decedent's Name (First, No. 1) Sharon Maria Aa. Facility Name (If not institute in the control of	e Est	leman	ımber)		4b. City,	Town, or	Location o		2. Date of Death Month August	Day	Year 005	3. Time of Death
	Funeral Director	lei	19218 Air V 5. Social Security Number 215–48–0579	iew F	Road	7. Age (In yrs	s. last birthday) 51 Yrs.	If Under Months		Hager If Under a Hours	stow	n 8. Date of Birth (Month, Day, Mar 10	Wash	ingto 9. Birthp Cour	on County lace (State or Foreign try)
	the Maryland 28a-f show	Director	Usual Residence of Deceder 10a. State 10b. Co Maryland Wa; 10e. Street and Number		rton	10c. C	City, Town or Lo	erstor				10	g. Citizen of \		0d. Inside City Limits 1 ☐ Yes 2√☐ No
9	4 within 72 hours after death with the Maryland Jene. r than "natural", or Itema 23a or 28a-f show the Medical Examinar must be notified at	Funeral	19218 Air V		12. Was Dec	edent Ever in orces?			lent of Hi	2174 ispanic Origin, Mexican Specify:		cify Yes or No- Rican, etc.)	U.S		ean Indian, etc.
21215-0036	within 72 hours ene. than "natural", he Medical Exal	Completed by	3 Widowed 4 Divo 15. Dece (Specify only h.) Elementary/Secondary (0-)	dent's Ed ghest gra	Year or l lucation de completed,	Dates:	16a. Deced	dent's Usua	Il Occupa	ation during most	of worki	ng 1	6b. Kind of B	usiness/In	dustry
Maryland 21	buld be fited Mental Hyg arked othe atic evant,	To Be Col	N/A 17. Father's Name (First, Mic	leman				Iomema		Or	pha ((First, Middle, N	n Eshl	eman	Residence
	ss 1 an of Heal itam 2 rothar		John M. Esh 20a. Method of Disposition 1 1 Tormati 1 Tormati Tormati Tormati Tormati Tormati Tormati	Leman	(Fat	20b. State	1921 Place of Dispo cemetery, crem	18 Air	Vie ne of ther plac	ew Rd	. Ha		Maryl Oc. Location -	and 2 City or To	21742 own, State
Baltimore,	permit. Page Department (important: if any injury or		21. Signature of Funeral Ser	lice Licen	Paule	JK		2. Name an	d Addres	s of Facility	Doi	ıglas A. N. Hage	Fiery rstown	Fune	Maryland eral Home cland 21742 Approximate
	Physician /Medical Examiner		shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	List only	a	(or as a conse	ufal	re	fa	dat	teor	~		4	Interval Between Onset and Death
,092	be executed sictan and buriat-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	c	(or as a conse	. ,			-					
.O. Box 687	at the death certificate I by the attending physi tached for use as the b	Physician/Medic	IF FEMALE: 23b. Was decedent pregnan in the past 12 month 1 □ Yes 2 ☑ √0 9 □ Unknown		1 Live	utcome of pregi birth 2 ☐ Fe nant at time of nown	tal death 3	Ectopic pro					23d. Da Mo	te of delive	ory D a y Year
Records, P.	The law requires that the ite has been signed by th bage 2 should be detache	by	Part II. Other significant cor	ditions c	ontributing to	death but not re	esulting in the u	nderlying ca	ause give	en in Part I.					ne cause of death?
Vital Rec		Be Completed	25. Was case referred to pre examiner?	dical								(Check only one	ed? No	prior to condeath?	
Division of \	ing Phys	Certification: To	1 Yes 2 No 27. Mann Death 1 atural 5 Pe 2 Accident inv	nding estigation	28a. Date (Moi		ER/Outpatien 28b. Time of Injury	-	8c. Injury Work	at at	2	ne 5 Tesider 8d. Describe hor			/)
Divi	To the Hospital or Attano within 24 hours after death To the Funaral Director: completely filled in by the i	edical Certifi	4 Homicide da 29a. Certifier 1 Cert (Check only 2 Med	ifying Ph	ysicien: To th	ling, etc. (Spec	nowledge, death	n occurred	at the tim	ne, date and	d place, a	esf. Location (Str City or Town, and due to the ca ad at the time, da	State) use(s) and ma	nner as st	ated.
)	To the twithin 24 To the f	Med	29b. Signature and title of ce	rtifier (and mai	MD		290	License	number 665	5	£29	d. Date signed	d (Month,	
44	5		30. Name and address of pe	,,,,	77.5. 1	V) 3	. 3017	Print) 2	00. 1	Hoge.	HOW	N MO	2174	10	7
	Sta Regist		31. Date filed (Month, Day,)	(ear)) & 2(005 32.	Registrar's Sign	nature G. Sp	uki		•					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 4:40 P M 26 ELIFF August **JOANNE** /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MONTGOMERY MONTGOMERY GENERAL HOSPITAL OLNEY If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan. 14, 1934 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 💢 F Yrs. Washington, D.C Director <u>577 50 2724</u> Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Silver Spring Md. Montgomery Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20906 2921 N. Leisure World Blvd. United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White δ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. othar than " Elementary/Secondary (0-12) College (1-4or 5+) Clerk Typist U. S. Government rmit. Pages 1 and 2 should be filed w partment of Health and Mental Hygier portant: if itam 27 is marked other tit yi injury or other traumatic avant. Its 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Reid Maxine H. ဂ္ John Matthews Eliff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17505 Gatsby Terrace, Olney, Md. 20832 Michael Block, Pers. Rep. Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 Removal from State permit. Page Department Important: If any injury o Columbia Gardens Cem. 8/29/05 Arlington, Va. 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home Julie P.O. Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) FAILURE RESPIRATORY Pnysician /Medical **Examiner** CHRONIC OBSTRUCTIVE PULMONARY YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner 99 or Attanding Physician: The law requires that the death certificate be execu use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined. 4 Homicide To the Hospital o within 24 hours aff To the Funaral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of contifier 29c. License number 29d. Date signed (Month, Day, Year) FAMILY August 27, 2005 034740 PHYSICIAN

State Registrar 31. Date filed (Month, Day, Year) 29 2005

P. FIELDS, M.D. - 18109 PRINCE 32. Registrar's Signature

PHILLIP

DR # 200

DLNEY

MD

20832

ss of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

oian		ne (First, Middle, La		_			2. Date of Death Month	er 06, 20	3. Time of Dear		
cian Iical			llington,		1		<u> </u>				
iner			re street and number) al Hospita		4b. City, Town, o Freder	r Location of Death rick	1	4c. County of De Frederic			
ıl r	5. Social Security f 081-52-2 Usual Residence of	2120	Sex 7. Ag 15⊈M 2□F	ge (In yrs. last birth 36 Y	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day NOV 9,	(Month, Day, Year) Country)			
	10a. State	10b. County	•	10c. City, Town				10d. Inside City			
ctor	PA	Frank1	.in	Wayne	esboro, Was	hington [1 ☐ Yes 2 ☑			
Funeral Director	10e. Street and Nu	orchard F	Road		10f. Zip Code	17268	109	•			
era	11. Marital Status		12. Was Decedent		13. Was Decedent of H If Yes, specify Cuba		pecify Yes or No-	USA 14. Race - Arr Black, Wh	rerican Indian,		
þ	1 ☑ Never Man 3 ☐ Widowed	ried 2 Married 4 Divorced	Armed Forces: 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:				o ritoan, etc.)	hite			
letec	(Spe	15. Decedent's E cify only highest gra		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			king	5b. Kind of Busines	s/Industry		
Completed	Elementary/Sec	ondary (0-12)	College (1-4or	5+)	Superviso	•		US Govern	ment		
BeC	17. Father's Name	(First, Middle, Last				18. Mother's Nan	ne (First, Middle, Ma	aiden Sumame)			
10 B		. Ellingt					a J. Whee?				
	2	lame/Relationship (1	Mailing Address (Street						
	Gerry C 20a. Method of Dis		con, Sr. i	20b. Place of I	1558 Orchard Disposition (Name of			PA 1/268 Oc. Location - City of			
	1 🖫 Burial 2	☐Cremation 3 5	Removal from State		, crematory or other plac Ii 11 Comete:	1	12 2005 น.	unachoro	DΛ		
á	4 Donation 5 Other (Specify) Green Hill Cemetery Sep 12 2005 Waynesbor 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Grove—Bowersox Fune										
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al Examine	Sequentially list or if any, leading or cause. Enter Und Cause (Disease or that initiated event resulting in death)	S	cDue to (or as	a consequence of							
/Medica	IF FEMALE: 23b. Was deceded	nt prognant	d			-		23d. Date of d	elivery		
Physician/M	in the past 12 1 Tes 2 9 Unknown	2 months?		2 Fetal death It time of death	3 □Ectopic pregnancy 5 □ Other (specify) _			Month	Day Year		
δ	Part II. Other sign	ificent conditions	contributing to death t	out not resulting in	the underlying cause giv	en in Part I.	23e. Did toba 1 ☐ Yes	_	to the cause of death Probably 4 Munkm		
Completed							24a. Was an autopsy performe	prior to	autopsy findings avail completion of cause is 2 \square		
Be (25. Was case refe examiner?	rred to medical	Hamilton.		100		th (Check only one)				
1.	1 1√2 Yes 2 ☐ 27. Mapner of Dea		Hospital: 1 ☐ Inpati 28a. Date of Inju			4 Nulsing n	ome 5 Residen		ecify)		
Certification:	1 Anatural 2 Accident 3 Suicide	5 Pending investigatio	(Month, Da	ay Year) In	ury Wor M 1	k? Yes 2 □ No			Rural Route Number,		
ertif	4 Homicide	determined		tc. (Specify)	π, street, factory, office		City or Town,				
	29a. Certifier (Check only one)	1 ☐ Certifying Pl 2 ☐ Medical Exe	hysician: To the best miner: On the basis of and manner st	of examination and	death occurred at the tin or investigation, in my o	ne, date and place pinion, death occu	, and due to the cau rred at the time, dat	se(s) and manner a e and place, and du	as stated. ue to the cause(s)		
dici	29b. Signature and	d title of certifier	1 ~ 1		29c. Licens	e number	290	d. Date signed (Mor	nth, Dey, Year)		
Medical		,, a A	1 2	/	0	C.M.E.	Se	ptember (7 2005		
Medici	30. Name and add	ress of person who	completed cause of	death (Item 23a) (T		.С.М.Б.	DC	prember (77, 2005		

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Day Year **Physician** August 27, 2005 8:25am^M Jose A. Fernandez /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min 1 XM 2 ☐ F Director 579-68-4766 64 Mar. 18, 1941 Spain Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28e-f show injury or other treumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 No Director Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ Pages 1 and 2 should be filed within 72 hours after death with items 23a United States 11903 Ashley Drive 20852 by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No 1 ☐ Never Married 2 Married ö Baltimore, Maryland 21215-0036 1⊠Yes 2□No Specify: Spanish If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced "naturai", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Food Service Restaurant Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental ! Hipolito Fernandez Cresencia Dominguez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Helga Fernandez (Spouse) 11903 Ashley Drive, Rockville, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Himportent: If ite any injury or of once. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 8/30/05 Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 21. Signature of Funeral Service Licensee 23a (Part1. Ente) the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Anoxic Encephalopathy disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of) Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760 IF FEMALE . If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, peq 1 Yes 2 No 3 Probably 4 Nuknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2X No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Certification: To 1 ☐ Yes 2x No 1 Inpatient 2 ER/Outpatient 3 DOA Hospice this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation i Director; Af d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be within 24 hours efter de To the Funerei Directo completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D41218 August 29, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Harrison 6001 Muncaster Mill Road, Rockville, MD 20855 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2005 AUG 30

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Johnny L. Ford August 28, 2005 7:15 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's Cheverly Prince George's Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □XM 2 □ F 74 Director 223-36-7330 Sept.3,1930 Culpeper, VA Usual Residence of Decedent 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits evant, the Medical Examiner must be notified at X Yes 2 No Director Capitol Heights Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö USA 20743 509 Quarry Avenue 'natural', or Itams 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Army 1 □Wes 2 □ No Army If Yes, Give Year or Dates. 2 / 52 – 2 / 54 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Black Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Item Na Elementary/Secondary (0-12) 12th College (1-4or 5+) Car Salesman Pvt. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Delzie Jameson Lester Ford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 509 Quarry Ave. Capitol Hts., MD 20743 Margaret W. Ford 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Denial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Fort Lincoln Cemetery 9-2-05 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home of MD 4308 Suitland Rd. Suitland, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pancreatic Carcinoma /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physicien Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy lor in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 3Д☐ No 24a. Was an autopsy performed? 1 Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 70 1 ☐ Yes 2 🗶 No 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28c. Injury at Work? e Hospital or Attending P 24 hours after death. a Funeral Director: After t 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) August 28, 2005 D0026024 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Lester Miles 6490 Landover RD. Suite F Landover, MD 20785 31. Date filed (Month, Day, Year, 32. Registrar's Signature AUG 3 0 2005 Registrar 7 79 10

		•	1- For State of Maryland / Departi	ment of Health and Ment icate of Death	al Hygiene Reg. No. 20	05 2992
	Physici		1. Decedent's Name (First, Middle, Last) James E. Fassett	M	ate of Death onth Day	Year 3. Time of Death
	/Medic Examir		The memorial Hospital	City, Town, or Location of Death	4c. County	of Death
	Funeral Director		213 16 7916 1 N 2 F 83 Yrs. M	onths Days Hours Min. (N	ate of Birth forth, Day, Year) 1 08 1922	Birthplace (State or Foreign Country) Maryland
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Md. Talbot	aston		10d. Inside City Limits 1XXes 2 ☐ No
	with the s or 28a be notifi	Director	10e. Street and Number	Of. Zip Code	10g. Citizen of V	Vhat Country?
936	ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, If a Medical Exercitrat roust be notified at	by Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 LMarried 1 X Yes 2 No	21601 Decedent of Hispanic Origin? (Specify Ys, s, specify Cuban, Mexican, Puerto Rican Yes 2 No Specify:		e - American Indian, ck, White, etc.
Maryland 21215-0036	2 should be filed within 72 hours and Mental Hygiene. Is marked other than "natural", raumatic event, It e Medical Exu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 1 2 5 + Doct	s Usual Occupation of work done during most of working NOT use retired)	16b. Kind of Bu	siness/Industry
yland	should be file nd Mental Hy, marked othe Imatic event,	To Be C	17. Father's Name (First, Middle, Last) James Andew Fassett	18. Mother's Name (First	, Middle, Maiden Sumam lla Hacket	t Fassett
	and 2 sho lealth and m 27 is m			ddress (Street and Number or Rural Roun Paris Lane Apt.)		
Baltimore,	Partition		20a. Method of Disposition 20b. Place of Disposition	n (Name of Date	20c. Location -	City or Town, State Maryland
Balti	permit. Depertm Importa any Inju		21. Signature of Funeral Service Liceosee 22. Na 31 S	me and Address of FacilityDashie East Dover St.	ell Funera	l DService Maryland
8760,	Physician /Medical Examiner physician and physician and physician and physician and the printing the printing of the physician and physician a	dicai Examiner	23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):	Halion Colon	natory arrest,	Approximate Interval Between Onset and Death I LUNS 20 day 15 day year
P.O. Box 6	The law requires that the death certific the has been signed by the attending prage 2 should be detached for use as	Physician/Mec		opic pregnancy er (specify)	23d. Date Mor	e of delivery hth Day Year
rds, P	quires that n signed b uld be deta	ρ	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I. 2	_	ibute to the cause of death? 3 Probably 4 ViUnknown
Reco	The faw requir te has been si age 2 should i	Completed	Diabetes wellities		autopsy p performed? d	Vere autopsy findings available rior to completion of cause of eath?
of Vital	Physician: The lar rthis certificate has ral director, page 2	To Be		26. Place of Death Che	ck on one	
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to	Certification:	1 Natural 5 Pending (Month, Day Year) Injury	Work? ### 1 ☐ Yes 2 ☐ No ###################################	cation (Street and Number ty or Town, State)	
	To the Hospita within 24 hours To the Funeral completely filled	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurrence of examination and/or investigated. Medical Examiner: On the basis of examination and/or investigated.	urred at the time, date and place, and dugation, in my opinion, death occurred at t	e to the cause(s) and mar he time, date and place, a	nner as stated. and due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number		(Month, Day, Year)
J id	min)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print		8	138105.
16	Sta Regist		Dr. Syed Ali, 506 Idlewilde Ave East 31. Date filed (Month, Day, Year) AUG 3 1 2005	on, MD 21601		

5 Edwin Fassett.

State of Maryland / Department of Health and Mental Hygiene 2005 29928 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 11:25 ^{a м} William Μ. Fisher August 25, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Under 1 Year | If Under 24 Hrs. 16913 Freedom Way Montgomery 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 ☑ M 2 □ F Yrs Director 213-54-6847 1949 Washington, DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits worle in then "neturel", or Items 23e or 28e-f ehove the Wadical Examiner must be notified at 1 Yes 2X No Funeral Director Maryland | Montgomery Rockville 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 16913 Freedom Way 20853 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. perriit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel", or Itel any njury goother treumatic event, the Marcial Examinations. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Heating and Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Air Conditioning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ William T. Fisher Margaret E. Cutler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16913 Freedom Way <u>Glenda D. Fisher</u> Wife Rockville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Aug. 29, 2005 Alexandria, Virginia 22. Name and Address of Facility
Collins Funeral Home, Inc. 21. Signature of Funeral Service Licensee 500 University Blvd., W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failure /Medical Due to (or as a consequence of): Examiner Lung Cancer Sequentially list conditions, I any, backing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last month Examiner Due to (or as a consequence or) The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy ō Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Colon Cancer, Metastatic Brain Cancer 1X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 2 X No 1 Yes of Vital Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 1 Yes 2 XNo 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 XNatural 5 Pending investigation after death.

Director: A in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitel within 24 hours a To the Funerel C 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D D 61630 August 25, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shishir K. Khetan, M.D. 1201 Seven Locks Road #111 Rockville, Maryland 20854 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 29 2005 Registrar

DIVISION OF VITAL IN To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined		At home, larm, s pecify)	treet, factory, offic	e e	28l. Location (Stre City or Town,	eet and Number or F State)	Rural Route Number,
ION O nding Pi ath. r: After the	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date ol Injury (Month, Day Yea	ar) 28b. Time (Injury	V	jury at fork? □ Yes 2 □ No	28d. Describe how	v injury occurred	
hysicia hysicia his certi	To Be	examiner?		2 ER/Outpatie	ent 3 DOA	Dub	th (Check only one one 5 Residen) nce 6 ⊡Other <i>(Sp</i> e	ecify)
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faw require as been sig 2 should t	pleted	Diabetes mellits,	hyportensia	01			1 Tes 24a. Was an autopsy		robably 4 Unknov lutopsy lindings availat completion of cause o
S, T.S. ss that the gned by a detect	by Phy	Part II. Other significant conditions co	1		underlying cause	given in Part I.	23e. Did toba	acco use contribute I	to the cause of death?
VISION OI VIIAI MECOLUS, F.O. DOX 00/00, Attending Physician: The faw requires that the death certificate be executed reach. Totath. Extor: After this certificate has been signed by the attending physicien and by the funeral director, page 2 should be deteched for use as the burial-transit	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnal	ncy		23d. Date of de Month	olivery Day Year
o / oU, cate be execu- ohysicien and the burial-tra	cal	resulting in death) Last	Due to (or as a cord.	nsequence of):					
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	7 ,	23a. Part 1. Enter the theast, or compositive, or heart failure. List only of timmediate Cause (Final	tions that caused the one cause on each line.			ALCOHOLD DE CONTRACTOR		st,	Approximate Interval Between Onset and Death
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Definition Pages 1 and Department of Health mportant: if Itam 27 any Injury or other tr		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☑ Donation 5 ☐ Other (Specify,	Removal from State	b. Place of Disp	osition (Name of matory or other p			Oc. Location - City of	
125 E	i	19a. Informant's Name/Relationship (T) Eva P. Fennell/spo				et and Number or Aut Mill Circ		,	
	To Be	John Fennell				Go1d	ie Hayes		
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	p	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	54-56	1□Yes 2∏N				black
ē = ē	Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married	12. Was Decedent Ever Armed Forces? 1 1 Yes 2 □ No	in U.S. 13.	Was Decedent o	Hispanic Origin? (Sp aban, Mexican, Puenc	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
h with t	al Dir	10e. Street and Number 6609 Spring Mill	Circle		10f. Zip Code	21207	10	g. Citizen of What C USA	ountry ?
death with the Maryland ims 23a or 28a-f ahow	Director	MD		Baltim					1√ Yes 2□
land ow		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or L	ocation				10d. Inside City Lim
Funer Directo		5. Social Security Number 6. Se 213–30–8501	JM 2□E	yrs. last birthday) 70 Yrs.	Months Day		8. Date of Birth (Month, Day,) Jan 26,1		thplace (State or Fore ountry) 'Yland
**************************************		Sinai Hospital et	100		Balton If Under 1 Yea		0 Day (B) 11		
	dical	Reginald P. Fenn 4a. Facility Name (If not institution, give			4b. City, Town	or Location of Death	September	6 200 4c. County of Dea	
Phys	ician	Decedent's Name (First, Middle, Last	,				2. Date of Death Month	Day Year	3. Time of Deat

		•	For State Registrar	State o	f Maryland	l / Depa <i>Cer</i>	artment of H tificate of L	ealth and Death	Mental Hy	giene 2 (305	29930
	D		1. Decedent's Name (First, Middle, L	.ast)					2. Date of De	ath Day	Year	3. Time of Death
	Physicia /Medic		JUNE FUNK						August		2005	10:30P ^M
	Examin		4a. Facility Name (If not institution, g	ive street and nur	mber)		4b. City, Town, or	Location of De	ath	4c. County of Death		
			Montgomery Gener				01ney			Mont	tgomer	У
	Funeral			Sex 1□M 25√F	7. Age (In yrs. la 75	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		th y, Year)	9. Birthp Coun	lace (State or Foreign try)
L	Director		121-22-9569 Usual Residence of Decedent			115.			June 23	1930	Broo	klyn, NY
	and and	1	10a. State 10b. County		10c. City,	Town or Lo	cation				1	Od. Inside City Limits
	Mary -f sh	ō	MD Montgom	ıerv	S	ilver	Spring				1	1 ☐ Yes 2 🛣 No
	1 the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	itry?
	3a o		14514 Homecrest	Road #I	L-3		20906			United	State	S
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9	after or Ita	Ē	1 ☐ Never Married 2 ☐ Married	Armed Fo 1 ☐ Yes If Yes, Giv	2 ☑ No	i	r ves, specπy Cuba 1 □ Yes 2 ☑ No	n, mexican, Pui Specify:	eπo Hican, etc.)		ack, White,	
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7	vithin ne. han	du	Elementary/Secondary (0-12)	College (1	1-4or 5+))				
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and	ntal led ol	Be		31)						, imaluen Suma	me)	
Maryland	hould d Me mark matic	ပ	Unknown 19a. Informant's Name/Relationship	(Type Print)		19h Mailir	ng Address (Street a		n Miller	or City or Tour	n State Zin	Codel
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ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Merlat Hygiene. Inportent: If Item 27 is marked other than "neturel; or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be retilied all once.		20a. Method of Disposition	dadgiicai	20b. Pla	ace of Dispo	sition (Name of	1	Date	20c. Location		
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薑	mit. I		21. Signature of Funeral Service Lic		Star	miord 22	Cemetery . Name and Address	ss of Facility H	ines-Rina	1di Fur	neral	Home, Inc.
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	-		23a. Part1. Enter the disease or co shock, or heart failure. List on	molications that c	caused the death.							Approximate Interval Between
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Вох	d for	ciar	in the past 12 months?		oirth 2 Fetal nant at time of de		Ectopic pregnancy Other (specify)					Day Year
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S, P	The law requires that the death certifi tte has been signed by the attending i tage 2 should be detached for use as	by P	Part II. Other significant conditions	s contributing to d	eath but not resul	lting in the u	nderlying cause give	en in Part I.		,		e cause of death?
rd	w require been signal	ed							1 🖫	Yes 2□No	3 ☐ Proba	ably 4 ⊡Unknown
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Vital Records,		Completed							perfo	rmed?	death?	
/ita	Physicien: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?					26. Place of D	eath (Check only	one)		
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u C	ling After une	lon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending		of Injury oth, Day Year)	28b. Time of Injury	Work		28d. Describe	how injury occu	irred	
isic	tend fleath for: the	icat	2 Accident investigat 3 Suicide 6 Could not	t be 280 Bloom	o of Injuny . At hor	mo farm str	M 1 1 1	Yes 2□No	29f Lagation /	Ctroat and Mum	abas as Gum	Route Number.
Division	the fire	ertification;	4 Homicide determine		ing, etc. (Specify)		eet, lactory, office		City or To		iber or nural	Houte Number,
_	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	0	29a. Certifier 1 Certifying	Physician: To the	e best of my know	vledge, death	n occurred at the tim	ne, date and pla	ce, and due to the	cause(s) and m	nanner as st	ated.
	ne Ho n 24 h ne Fu vietely	edical	(Check only 2 Medical Ex	(aminer: On the b	pasis of examination in a stated.	on and/or in	vestigation, in my or	oinion, death oc	curred at the time,	date and place	, and due to	the cause(s)
ı	To the To the To the Comp	Me	29b. Signature and title of certifier				29c. License			29d. Date sign		
	7-) graph n	Jan w	0		023	650		AUGUS	7 24.	2005
			30. Name and address of person wh	no completed caus	se of death (Item	23а) (Туре,	Print)			1	,	4 1
			FRANG J. MAYO.					10 202	16 213	bg.th.v	sour,	10807
	Sta Registi		AUG 2 6 2	005	Registrar's Signati	UT GOD	el s					

			State of Man	yland / Depa Cer	artment of He rtificate of D	ealth and M Death	lental Hygien	e 200	5 29931		
			Registrar 1. Decedent's Name (First, Middle, Last)	001	incate of E	Call	2. Date of Death	10.	3. Time of Death		
	Physicia /Medic		HAROLD Y. FINCK				AUGUST 22,	2005	3:30 P M		
	Examin	÷.	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I	Location of Death	4	4c. County of Death			
		*	MONTGOMERY GENERAL HOSPITAL 5. Social Security Number 6. Sex 7. Age (I	In yrs. last birthday)		LNEY If Under 24 Hrs.	8. Date of Birth	MONTG			
	Funeral Director		057-16-9794 1MM 2□F	91 Yrs.	Months Days	Hours Min.	07/02/1914	NEW	hplace (State or Foreign untry) JERSEY		
	and w		Usual Residence of Decedent 10a. State 10b. County 16	Oc. City, Town or Lo	cation				10d. Inside City Limits		
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	ath wi	rai	3701 BLOOMSBURY COURT			20906			S.A.		
	ter de: Itams rer	une	11. Marital Status 1 □ Never Married 2 ☑ Married 12. Was Decedent Eve Armed Forces? 1 ☑ Yes 2 □ No	er in U.S. 13. V	Was Decedent of His If Yes, specify Cuban	panic Origin? (Sp , Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White			
	filed within 72 hours after death with the Maryland Hyglene. thar than "natural", or Itams 23a or 28a-f show thar than "natural", or Itams 23a or 28a-f show int, it e M-cilcal Exeminant	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes. 2 ☐ No If Yes, Give Year or Dates:	WWII	1□Yes 2∏ No	Specify:		Specify: WH	IITE		
ה כ	72 ho 'natur	eted	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupat	iring most of work	ing 16b.	Kind of Business/	Industry		
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<u></u>	uld be Menta Menta Irkad Irkad	To B	MOSHE GERSHON FINKELSTEIN			SARAH EP	STEIN				
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ב ע	1 and Health am 27 thar t	100	HILDA FINCK/WIFE 20a. Method of Disposition					PRING, MA	RYLAND 20906		
Dallinor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if itam 27 is marked other than "natural; or Itams 23a or 28a-f show any injury or other traumatic avent, if a Modical Exercitor must be notified as once.		'4 Donation 5 Other (Specify)		ID MEML GD	NS 08/24	/2005 FAI	LS CHURC	CH, VIRGINIA		
סמ	permit Depar Impor any in	2 3	21. Ignature of Lameral Service Licensee	$\begin{array}{c c} D^2A \\ \hline 11 \end{array}$	NZANSKY™S L70 ROCKVI	O'EDBERG LLE PIKE	MEMORIAL O	CHAPELS, LE, MARYL	INC. AND 20852		
	Frysician /Medical Examiner	L.	23a. Part. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Due to (or as a condition to leading to immediate)	70SQbsi	er the mode of dying	, such as cardiac (or respiratory arrest,		Approximate Interval Between Onset and Death		
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O. Box 6	death certif e attending d for use as	hystcian/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of 1 Live birth 2 (4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	ivery Day Year		
cords, r	requires that the een signed by th hould be detache	by P	Part II. Other significant conditions contributing to death but a prostate mangranus,	not resulting in the un hypest	nderlying cause give	n in Part I.		A	the cause of death?		
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VITAL	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner? Hospital:		Otho	Pr.	h (Check only one)				
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DIVISION	pital or Attano ours after death aral Diractor: filled in by the	ertification;	2 Could not be	r - At home, farm, str (Specify)			28f. Location (Street City or Town, Sta	(Street and Number or Rural Route Number, อพา, State)			
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifica	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of evaluation and manner state and manner state.	xamination and/or in-	h occurred at the time vestigation, in my op	e, date and place, inion, death occurr	and due to the cause red at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)		
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	(0		30. Name and address of person who completed cause of dea Reger Leonard MD . 181	th (Item 23a) (Type,	e Philip D	u. 0/n	ey mi)	just 22 20832			
	Sta Regist		31. Date filed (Month, Day, Year) AUG 2 6 2005	DI Princ	ule		1, -				

State of Maryland / Department of Health and Mental Hygiene 2 For State Registra Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 20, BERTHA AUGUST C. **GOMEZ** 2005 11:30 P^M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year **Funeral** Birthplace (State or Foreign Country) Months Days 1 ☐ M 2 🖾 F Hours 96 Yrs. Director 579-09-1097 Wash., DC 1908 Nov 16, Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location ir than "natural", or Items 23a or 28e-f show the Medical Examiner and be notified at 10d. Inside City Limits 1 ☐XYes 2 ☐ No Directo Prince George's Mt. Rainer 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3216 Chillum Rd. #103 20712 Funeral United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Graphic Type Operator Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be f and Mental H is marked of Pages 1 and 2 should be timent of Health and Menter tant: If Itam 27 is marked Peter Spriggs Annie Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vernon Gomez / Son 5420 Kenilworth Terrace Riverdale, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State № Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or * 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cemetery Washington, D.C. 9-3-05 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Capitol Mortuary, Inc. 1425 Maryland Ave., NE Wash., DC 20002 oplications that caused the death. Don't enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Parti. Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ASDIratio disease or condition /Medical resulting in death) Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Office of the Conditions of the Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown þ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes Division of Vital 2 - No the Hospital or Attanding Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 🔀 No Impatient 2 ER/Outpatient 3 DOA After this funeral c 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Medical Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pendina death. 2 Accident investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide hin 24 hours a 152 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 2 D45660 and address of person who completed cause of death (Item CX CAS, 124 CHLCAN 31. Date filed (Month, Day, Year) AUG 2 9 2 22. Registrar's Signature 9 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Reg. No ZUO Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2005 liam 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Lions Manor Nursing Home Cumberland Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) Aug 10, 1917 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign MD Try) 1√ M 2 F Min Months Days Hours Yrs. 88 214-07-6642 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits LaVale Allegany 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 904 Weires Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: white 3 →Widowed 4 □ Divorced Year or Dates: WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) salesman Willett Drug Cc. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Howser Green William Henry Green Alice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melanie Pratt granddaug 10128 Piney Mt. Road Frostburg MD 21532 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State **Bittinger Cemetery** 9/13/2005 MD Bittinger 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, P.A. 21. Signature of Funeral Service Licens 108 Virginia Avenue; Cumberland, MD 21502 23 Part | Enter the disease, or complications that caused the death. Do not enter shoot, or heart failure. List only one cause on pach line. Approximate Interval Between Onset and Death the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) clevote Due to (or as a consequence of)

Physician /Medical **Examiner**

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Hospital or Attending Physician: The law requires that the death certificate be execut

Box 68760,

P.O.

Division of Vital Records,

permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trat once.

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Pages 1 and 2 should and l other traumatic avent, the Mudical Examiner must be notified at

be filed within 72 hours after death with

Be Compieted by Funeral Director

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physiclan/Medical Examiner that initiated events resulting in death) Last

١	cDue to (or as a consequence	of):		
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	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day	Year

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Dither significant conditions contributing to death but not resulting in the underlying cause given in Part I. recec 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

and manner stated

23e. Did tobac	co u <i>s</i> e con	tribute to the cau	se of death?
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ble of

24a. Was an autopsy performed? 1 ☐ Yes 2 No	24b. Were autopsy findings availa prior to completion of cause death? 1 ☐ Yes 2 No
Check only one)	

26. Place of Death Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print)

State Registrar

V.A. Ranjithar

29b. Signature and title of certifier

30. Name and address of person

Furnace Street Ext. Cumberland MD 21502

1 4 2005

32. Registrar's Signature, PREM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** AugusT 1850 M Guinevere Groce 25 2005 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Regional Medical Center VICONICO If Under 1 Year | If Under 24 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🖾 F 508-50-2453 Director 64 <u>Jan</u> 14, 1941 Missour Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Be Completed by Funeral Director 1 ☐ Yes 2 No MD Wicomico Pittsville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 35210 Laws Road or items 23a <u> 21850</u> <u>USA</u> 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ≥ ∑No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Cashier Retail other traumatic event. Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) UNK if Health and Mental if Mark Richards Marie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35210 Laws Road Samual Groce-husband Pittsville, MD 21850 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ö 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 8/26/2005 Delmar, Delaware 21. Signature of Fundral Service Licensee 22. Name and Address of Facility Bounds Funeral Home 705 E Main Street Salisbury, MD 21804 complications that when death. Do not enter the mode of dying, such as cardiac or respiratory arrest, as tonly one cause and line. 23a. P. 11. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final 🕖 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Mars Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a construence of): g physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed + Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2√ No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA the funeral 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 61627 amon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRMC 100 E. Carroll St. Salisbury md. 21801 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 2 6 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** GRAY 3:00 AM DEREK 10142 28 AUGUST 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 40082 Branca Drive Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. B. Date of Birth (Month, Day, Year) Jan 27, 1973 Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 XM 2 ☐ F Months 32 601-58-6173 Jan AZ Director Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehov notified at 1 ☐ Yes 2 🔀 No MD Frederick Director Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral', or Itams 23a or Examiner must be 40082 Branca Drive 21702 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Italy injury or other traumatic event, the Medical Examinate Roca. 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disc Jockey Entertainment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John D. Gray 2 Sue Anne Lytle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife 40082 Branca Dr., Frederick, MD 21702 Corynn Gray 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State

'4 □ Donation 5 □ Other (Specify) Green Hill Cemetery Aug 29 2005 Waynesboro, PA 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc. 21. Signature of Funeral Service Licensee James G. Berlessey 50 S. Broad ST. Waynesboro, PA 17268 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** SARCOMA ABOOMINAL 4 EAR resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) ☐Yes 2☐No o. 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 3 DOA in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical MEDIENL DIRECTER 29b. Signature and title of certifier itaspice of 29c. License number 29d. Date signed (Month, Day, Year) D10587 131 /05 1-2 . Als Deducas Co. 16 TUTIL AUE s of person who completed cause of death (Item 23a) (Type, Print) MEDICAL DIRECTOR HOSPICE OF ALEXPICK CO. GEORGE 1. SMITH. 32. A sistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** BLANCHE H. GARDNER AUG. 25, 2005 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SUNRISE ASSISTANT LIVING SILVER SPRING MONTGOMERY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday). 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 1 ☐ M 2 🕱 F Director 350-12-7226 Yrs. 86 30, 1918 ILLÍNOIS Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturat", or Items 23a or 28a-f show eny injury pe 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No NONE D.C. WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? CONNECTICUT AVE. N.W.#210 4600 20008 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3X Widowed 4 ☐ Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) LANGUAGE TEACHER PRIVAT SCHOOL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JAMES HATFTELD **ESTELLE** ဂ္ဂ CARAWAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANN MARTIN/DAUGHTER 1858 ST. MARGARETS RD., ANNAPOLIS, MD. 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 8-27-2005 RIVERDALE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 M00091 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ordiac disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to infine data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐ Pregnant at time of death 5 Other (specify) P.O. I 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 **N**O 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 X Other (Special SSISTED) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 4566 30. Name and address of person who completed cause of death (Hom 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

DPINDER

AUG

29

31. Date filed (Month, Day, Year)

SINGH, M.D.

2005

32 Registrar's Signature

14300 GALLANT FOX LA. #124, BOWIE, MD. 20715

	تنو	1 - State Registrar 1. Decedent's Name (First, M.	fiddle, Last)	State of M		Ce	rtificat	te of L	Death		2. Date of De	Reg. No. 2	005	290
Physic /Medi Exami	cal	Joseph 4a. Facility Name (If not instited) 14913 Howard	Ed		Hı ər)	ull	Cres	sapto			Month 9 -	Alleg	Year Sunty of Death	1:07
Funeral Director		5. Social Security Number 219-54-2040 Usual Residence of Deceden	-	M 2□ F	Age (In yrs. 56	last birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da Dec 4,	1948	9. Birti Co MI	hplace (State or untry)
8e-f show	ector		_{unty} legany		10c. Ci	ty, Town or Lo Cresa		'n						10d. Inside City 1 ☐ Yes 2
23a or 2	ai Dire	10e. Street and Number 14913 Howard	d Stree	et			10f. Zip		1502			10g. Citizen	of What Co	untry?
or 2 should be litted within 72 hours after useful with the Maryland than and Mental Hygiene. 27 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examples must be rediffed at	d by Funeral Director	11. Marital Status 1 Never Married 2 7 3 Widowed 4 Divor	Married	2. Was Decede Armed Force 1 ☐ Yes 2 If Yes, Give Year or Date:	s?		Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto f	cify Yes or No Rican, etc.)		Race - Amei Black, White Boolfy: Whi	e, etc.
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and 2 should salth and Manal III and I		19a. Informant's Name/Relat Sheila Hull	ionship (Typ	e, <i>Print)</i> wife		19b. Mailii 1491	ng Address 13 Hov	s (Street a ward	Stree	r o <i>r Rur</i> ai et	Cresa	er, City or Tov aptown		iip Code) MD 2150
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ORIGINAL

			1 - For State Registrar		-	partment of Hea ertificate of De			ag. No. 2005	29938
	Physicia	an	1. Decedent's Name (First, Midd					2. Date of Deat Month	th Day Year	3. Time of Death
	/Medic		Joseph Hal					August	20, 2005	3:00 p. M
	Examin	er	4a. Facility Name (If not institution 6206 Balfour I	•		4b. City, Town, or Loc Hyattsvil			4c. County of Dea Prince (
	Funeral Director		5. Social Security Number 176-22-1494	6. Sex 7. Ago 1 2 M 2 ☐ F	9 (In yrs. last birthda 77 Yrs.		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 18,	9. Bir 1928 Per	thplace (State or Foreign puntry) Insylvania
	and w		Usual Residence of Decedent 10a. State 10b. Count	v	10c. City, Town or	Location				10d. Inside City Limits
	Maryl	ō	MD Prince	George's		attsville				1 ☐Wes 2 ☐ No
	r 28a	Director	10e. Street and Number	dedige b	*1170	10f. Zip Code		1	0g. Citizen of What Co	ountry?
	th with	aiD	6206 Balfour	Drive		2078	2		USA	
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heatile and Mental Hygiene. Important: If tiern 27 is marked other then "netural", or itema 23a or 28a-f show important: If tiern 27 is marked other then "netural", or itema 23a or 28a-f show eny injury or other traumatic event, the Madical Examinar must be notified at once.	by Funerai	11. Marital Status 1 □ Never Married 2 □ Ma 3 □ Widowed 4 □ Divorce	If Vac Give		3. Was Decedent of Hispa If Yes, specify Cuban, M 1 ☐ Yes 2 ☒ No S	nic Origin? (Spe Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
3	tural cal E			nt's Education	16a. Dec	cedent's Usual Occupation	n		16b. Kind of Business	
2	hin 72 Bu "ne Mad	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (1-4or 5	(Gi	ve kind of work done durin DO NOT use retired)	ng most of workin	g		
7	od with	Com		4	''	Electrical	Engineer		U.S. Gov	t
2	be file d oth event	Be	17. Father's Name (First, Middle	-					Maiden Surname)	
2	Men Marke Marke	٩	Mathew Halcha				Mary Wat			
<u> </u>	d 2 st th and 7 is n traun		19a. Informant's Name/Relation Diana Townsend			iling Address (Street and Greer Ct.		Route Number, .11s, MD		Zip Code)
ני	Healt Healt em 2	J X	20a. Method of Disposition	/ Pers. Rep.		position (Name of rematory or other place)	1111		20c. Location - City or	Town, State
5	Pages Iment of tent: If it jury or o		1 ☐ Burial 2 【**Cremation 4 ☐ Donation 5 ☐ Other (\$	Specify)	Metropo]	litan Cremat		26/2005	Alexandria	
0	Departit Deper Impor eny in		21. Signature of Funeral Service	an Pruel		22. Name and Address of 5512 NW Crain		ll Fune Bowie,		5
	Physician /Medical Examiner	ıer	23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Hyperfly Due to (or as:	0.	inter the mode of dying, su				Approximate Interval Between Onset and Death
,00100	icate be executed physicien and s tha burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a	a consequence of):					
.C. DOY	To the Hospitel or Attending Physicien: The law requires that the death certif within 24 hours afterder at the transfer of the theoretal Director After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of del Month	ivery Day Year
1 (22)	equires thaten signed build be de	þ	Part II. Other significant condition Chronic Glo	ions contributing to death but to have the	at not resulting in the	underlying cause given in	Part I.		acco use contribute to s 2 □ No 3 □ Pr	the cause of death?
מבינו	: The law racate hes be page 2 shi	Completed						24a. Was ar autopsy perform 1 X Yes 2	y prior to o	topsy findings available completion of cause of 2 No
) i	iclen certifi ector	Be	25. Was case referred to medica examiner?	Hospital:			. Place of Death	Check only one	a)	
5	Phys this ral dir	2	12∑ Yes 2 ☐ No 27. Manner of Death	1 🗆 Inpatiei					nce 6XIOther (Spec	ofy) At scene
5	ending sath. or: After he fune	ertification;	1 Natural 5 ☐ Pendi 2 ☐ Accident invest	igation	Year) Injury	Work?	2 □No	od. Describe no	w injury occurred	
	tel or Att rs after d at Direct ed in by t	Certific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern		ry - At home, farm, s . (Specify)	street, factory, office	21	Bf. Location (Str. City or Town,	eet and Number or Ru , State)	ral Route Number,
	To the Hospitel or Attending Physicien: The I within 2 Hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edicai	29a. Certifier 1 Cartifyi (Check only one) 2 XMadical	ng Physician: To the best of Examiner: On the basis of and manner sta	examination and/or	ath occurred at the time, d investigation, in my opinio	tate and place, ar on, death occurred	nd due to the ca d at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
	To t com	Σ	29b. Signature and title of certified Pahilul	us Ali		29c. License nur OCME	mber		August 21,	
	(3)		30. Name and address of person	9H ALI		III Penn	Street	Baltin	nore, Maryl	and 21201
	Sta	te ar	31. Date filed (Month, Day, Year AUG 2 9 2	2. Registra	r's Signature	all o				

DHMH 17 Rev 1/2001

ORIGINAL

	ın	1 Decedent's Name (First, Middle, Last Tracy Hollman	Tra	acy 1	Hollma	an		2. Date of Death Month 08 - 13		2005 Year	3. Time	of De
ledic: amine		4a. Facility Name (If not institution, give	street and number)			4b. City, Tow	n, or Location of Dea			County of Death	1.10	
		Prince George's H	ospital Co	enter		Chev	erly		Pr	ince Ge	orge's	3
eral ctor		5. Social Security Number 6. Se 217–84–9008	x	48	st birthday) Yrs.	If Under 1 Ye Months Da			Year) 957	9. Birthp Cour Nort	h Caro	or Fo
3		10a. State 10b. County		10c. City,	Town or Lo					1	0d. Inside (-
diffes	Funeral Director	D.C.			Was	shingto					1. X Ye	s 2[
9	בוב	401 56th Street,	C E			10f. Zip Cod		10	lg. Citiz	en of What Cour	ntry?	
E E	nera	11. Marital Status	12. Was Decedent E	ver in U.S.	. 13. V		019 of Hispanic Origin? (Juban, Mexican, Pue	Specify Yes or No-	1	4. Race - Americ		
	þ	1X Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	Armed Forces? 1 ☐ Yes 2 X N If Yes, Give Year or Dates:	lo		Yes X		nto Hican, etc.)		Black, White, Specify: Black		
SAICE	Completed	15. Decedent's Edu (Specify only highest grad	ucation le completed)		16a. Deced	lent's Usual Ockind of work do	cupation ne during most of wi tired)	orking 1	6b. Kin	d of Business/In-	dustry	
II 6 N	ошо	Spec. Edu.	College (1-4or 5-			al Edic			eci	al Educ	ation	
vent.	BeC	17. Father's Name (First, Middle, Last)		,			18. Mother's Na	ame (First, Middle, M				
atice	P.	Walter Hollman						ine McVay				
treum		19a. Informant's Name/Relationship (T) Geraldine Hollman/		, ii	19b. Mailin 5121	g Address (Str Fitch S	treet, S.	Ru <i>ral Route Number,</i> E. #102	City or	Town, State, Zip	Code)	
other	-	20a. Method of Disposition		20b. Plac	ce of Dispo	neton, sition (Name of natory or other	D.C.	Date 2	Oc. Loc	ation - City or To	wn, State	
iry or		1 XBurial 2 ☐ Cremation 3 ☐ F 1 4 ☐ Donation 5 ☐ Other (Specify)				tion Ce		0-05	Clin	ton, Ma	rylan	f
any inju		21. Signature of Funery Service Licens	Bacon C	136				H. Bacon F N.W. Wash				2.
4		23a. Part1. Enter the disease, or composhock, or heart failure. List only o	lications that caused ne cause on each lin	the death. e.	Do not ente	er the mode of	dying, such as cardia	ac or respiratory arres	st,		Approxima Interval Be	twee
ian		Immediate Cause (Final disease or condition resulting in death)	a Sepsis								Onset and	Dea
ical ner		resulting in death)	Due to (or as a	a conseque	nce of):							
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ourial	EX	resulting in death) Last	Due to (or as a	i conseque	nce of):							
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use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of						23	3d. Date of delive	ry	
	sicia	in the past 12 months?	1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown			Ectopic pregna Other (specify				Month	Day	Year
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letached for use as the	þ	Part II. Other significant conditions co	ninouting to death bu	น เเดเ เลรนเน	ing in the un	idenying cause	given in Part I.	239. Did (00a		e contribute to th No 3 ☐ Prob		deati Unkr
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funeral director, page 2 should be d	ledical Certification; To Be Completed	examiner? 1 Xyes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	28a. Date of Injun (Month, Day) 28e. Place of Injun building, etc sician: To the best of ner: On the basis of	ry - At hom . (Specify) If my knowle examination	8b. Time of Injury e, farm, stre	28c. Ir M 1 Deet, factory, office occurred at the estigation, in m	Other: 4 Nursing Nury at Vork? Yes 2 No ce	And the time, dat	v injury eet and State) see(s) a e and p	occurred Number or Rura nd manner as st lace, and due to	ated. the cause(s	

State of Maryland / Department of Health and Mental Hygienery 1 - For State Registra 29940 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Aug. 26, 2005 Ε. 7:20 A M Wilda Hodges /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery National Lutheran Home | If Under 1 Year | If Under 24 Hrs. | B. Date of Birth (Month, Day, Year) | Feb. 24, 1918 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 ☐ M 2 💢 F 177-09-1439 Yrs. 87 Director Pennsylvania Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mantal Hygiena.
and: If item X7 is marked other than "natural; or items 23a or 28a-1 show and it if it is not othat traumatic event, it is Mades Exactinat must be notitined at Rockville Md. Montgomery X□Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20850 9701-Veirs Dr. USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Year or Dates: Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Clerical 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilda Boyer Byron Rogers 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6102- Eagle Landing Rd., Burke, Va. 22015 19a. Informant's Name/Relationship (Type, Print) Mark Hodges- Son 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory-8/29/05-Alexandria, Va. rtment . ⁴ 4 □ Donation 5 ☐ Other (Specify) niury permit.
Dep rtr
Imports
any nju 21. Signature of Funeral Service 22. Name and Address of Facility Hysong Co., Inc.-6510-16th St., NW, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Enysician 6 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease of injury) Examiner ato (or as a consequence of) The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last wter Due to (or as a consequence of) Box 68760, Be Completed by Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 1 ☐ Yes 2 NO Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending after death. Diractor: A 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To ths 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) aresh 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Karesh-9701-Veirs Dr., Rockville, Md. 31. Date filed (Month, Day, Year) 2. Registrar's Signature State AUG 3 0 2005 Registra

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year John Holmes Heffron 11:40 p.^M 2005 27, /Medical August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1701 Glenkarney Place Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1X0M 2□ F Yrs. 152-26-8005 Director 72 Washington, July 6, 1933 Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location r then "naturel", or Items 23e or 28e-f show the Medicul Examinar must be notified at 10d. Inside City Limits Maryland Montgomery Silver Spring Director 1 ☐ Yes 2 XNo with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1701 Glenkarney Place 20902 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married 1 X Yes 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: 1955–57 þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ifiled within I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 end 2 should be filed wit Department of Health and Mental Hygiens importent: If tem 27 ie marked other the any injury orgither treumatic event, the once. Bookkeeper 4 Bookkeeping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Louise Ann Howze Edward Joseph Heffron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Mary Heffron / Wife 1701 Glenkarney Place, Silver Spring, MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State September ry 2005 1 Waurial 2 Cremation 3 Removal from State Gate of Heaven Cemetery Silver Spring, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Framers Advess Cornins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. oproximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Carcinoma of bladder 10 vears /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine burial-transit certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Box 68760 lan/Medical as the b IF FEMALE: use a 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Day Year Physici 4□Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 XNo 1 ☐ Yes 2 ☐ No the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 XNo this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide I in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funerel D 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai (Check only one) 29b. Signature and title of of tifier 5 29c. License number 29d. Date signed (Month, Day, Year) August 29, 2005 rVA D 09834 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Barry N. Rosenbaum, M.D., 3720 Farragut Ave., Kensington, Maryland 20895-2110 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 3 0 2005 Registrar BRUKEN

			1 - For State Registrar	State of Maryland	d / Depa	artment of H tificate of L	ealth and Death	Mental Hygi	ene _{g. No.} 2005	29942
	Physicia /Medic	al	Decedent's Name (First, Middle, Last) EMILY GREISMAN HAK 4a. Facility Name (If not institution, give s			th City Town or	Logation of Doub		25, 2005	3. Time of Death 8:20 P
	Examin	er	12602 TAYLOR COURT		at histogram	4b. City, Town, or SILVER If Under 1 Year			1	GOMERY
	Funeral Director			7. Age (In yrs. la M 24 82	Yrs.	Months Days	Hours Min.		9. Bir 23 PO1	thplace (State or Foreign puntry) AND
	h the Maryland rr 28e-f show protified at	ctor	10a. State 10b. County MARYLAND MONTGOM		Town or Lo	cation ER SPRING	3			10d. Inside City Limits 1 Yes 2 □ No
	with the	Directo	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	,
5-0036	hin 72 hours after death with the Maryland a. Macircal Examiner must be notilled at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		20904 Was Decedent of Hi f Yes, specify Cubar 1 ☐ Yes 2 ☑ No		Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Specify:	
D-6121	ithin 72 ne. nen "ne.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired, FILE CLF	luring most of wo)	rking 1	6b. Kind of Business	,
/iand 2	ad other	To Be Co	17. Father's Name (First, Middle, Last) PINCUS GREISMAN				18. Mother's Na	me (First, Middle, M	aiden Sumame)	MACE
Mar	es 1 and 2 should of Health and Men fitem 27 is marka r other traumatic		19a. Informant's Name/Relationship (Type) DR. RAZIEL S. HAKII						City or Town, State,	
altimore,	Pages 1 and 2 nent of Health int: if item 27 iry or other tri		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re 1 □ Donation 5 □ Other (Specify)	20b. Pla	ace of Dispo	sition (Name of natory or other place	9)	Date 2	ING,MARYI Oc. Location - City or DYNTON BEA	
Balti	permit. Pages 1 Department of H important: If ite any injury or ott		21. Senature of Financia Service License	е					CHAPELS,	
e P.	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each lineADVANCED_DEN	MENTIA	er the mode of dying	g, such as cardia	c or respiratory arres	st,	Approximate Interval Between Onset and Death YEARS
	Examiner	er	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence to (or as a consequence)						
8/60,	ate be executed thy sician and the burial-transit	dicai Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent	ence of):					
O. Box 68	ath certific thending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown	ic. If yes, outcome of pregnan 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	ivery Day Year
1	quires that the de n signed by the a uld be detached t	by	Part II. Other significant conditions conf	ributing to death but not resul	ting in the u	nderlying cause give	on in Part I.			o the cause of death?
Vital Records,		Completed						24a. Was an autopsy perform	24b. Were at prior to death?	utopsy findings available completion of cause of
	Physicien: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 Inpatient 2 E	R/Outpatien	t 3 DOA Othe		ath <i>Check on one</i>	nce 6 Other (Spe	cifu)
ion of	ding Pr	ertification; T	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Injury Work	at ? ′es 2 □ No	28d. Describe hov		5.177
Division	To the Hospitei or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	0	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)				City or Town,	·	
	is Hoep 24 hou e Fune letely fil	edical	29a. Certifier 1	ician: To the best of my know er: On the basis of examinati and manner stated.	rledge, death on and/or in	n occurred at the tim vestigation, in my op	e, date and place inion, death occu	e, and due to the cau urred at the time, dat	use(s) and manner as e and place, and due	stated. to the cause(s)
		Me	29b. Signature and title of certifier	-00.	000	29c. License	number 8262		d. Date signed (Mont	
	Q		30. Name and address of person who con	mpleted cause of death (Item	23a) (Type,	MA		AC	,3001 20,	2003
		la.	DR. ANURITA MENDHII	RATTA, 2401 RE		H BLVD, S	UITE 330	, ROCKVII	LLE, MARYL	AND 20850
	Sta Registr		AUG 3.0 2005	1.0	apa	MALI				

		1 - For State Registrar	State of Maryland		artment tificate			and M		iene,	2005	29943
Physic	ian	Decedent's Name (First, Middle, Last) James Roy Hager	ovor Tr						2. Date of Death Month	Day	Year	3. Time of Death
/Medi Exami		4a. Facility Name (If not institution, give s	neyer, Jr.		4b. City,	Town, or	Location o	f Death	August		county of Deat	0929 M
		12612 Kern WOT	od Lave			B	our			Pr	ince	6 eage's
Funeral Director		212-08-7098	7. Age (In yrs. Ia 50	st birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, Apr. 27	, 195!	9. Bird Co Was	nplace (State or Foreign untry) Sh., D.C.
land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation							10d. Inside City Limits
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show important: If item 27 is marked other than "natural", or Items 23a or 28a-f show important is usable notified at 2008.	tor	MD Prince G	eorge's	В	owie							1 XYes 2 ☐ No
th the	Director	10e. Street and Number			10f. Zip	Code			10	0g. Citize	on of What Co	untry?
ath wi	rai	12612 Kernwood La					715				USA	
ter de Items	Funeral	11. Marital Status 1 Never Married 2 Married	 Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 X No 	. 13. V	Was Decede f Yes, speci	ent of His ify Cubar	panic Orig n, Mexican	gin? (Spe , Puerto	cify Yes or No- Rican, etc.)	14	I. Race - Ame Black, White	
ours af	by	3 Widowed 4 Divorced	If Yes, Give "Year or Dates:	1	1 ☐ Yes 2	!□XNo	Specify:			s	Specify: Whi	te
72 hc	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	ient's Usua kind of world DO NOT use	l Occupa k done di	tion uring most	of worki	ng	16b. Kind	of Business/	ndustry
within ane.	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		no not us noine					mio	n Conti	-atox
filed Hygie other	ပိ	17. Father's Name (First, Middle, Last)	3	E	потпе	-	18. Mothe	r's Name	(First, Middle, N			actor
uld be fental rked o	To Be	James Roy Hagemer	yer, Sr.						Loving			
2 should and Men is marke sumatic		19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailin	g Address	(Street a	nd Numbe	r or Rura	l Route Number,	City or	Town, State, Z	ip Code)
and lealth im 27		James R. Hagemeyer			1/2]		ier R		Brunsw			
Pages 1 and nent of Health nt: If itam 27		20a. Method of Disposition 1 Aburial 2 Cremation 3 Re	emoval from State	netery, cren	natory or ot	her place					ation - City or	
nit. Prartme artme ortani Injury		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 		r Hil					/2005 3 11 Fune:		land, N	4D.
Depa Impo any L		Buan	Vouell	6	512 N	W Cr	ain H	wv.	.ii Funei Bowie	rai i . MD	ноте • 2071	5
145		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death, e cause on each line.					-				Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	Dia	bete	is 1	Mel	citu	5				Onset and Death
/Medical Examiner		Tosuling in doziny	Due to (or as a conseque	ence of):								
	Jer	Sequentially list conditions, any leading to in neciate cause. Enter Underlying	Due to (or as a conseque	nas cit):								
acuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last										
cate be executed obysician and the burlal-transit	a Ex	resulting in death) Last	Due to (or as a conseque	ence of):								
ficate physics the	edicai	d										
h certil	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnan		le .					23	d. Date of deli	very
The law requires that the death certific. The law requires that the death certific ate has been signed by the attending progge 2 should be detached for use as it.	hysician/Me	in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea 9 ☐ Unknown		Ectopic pre Other (spe						Month	Day Year
hat the	0	9 ☐ Unknown Part II. Other significant conditions con		ting in the ur	adorhina an		a in Dant I		22a Did tob		a a a a tributa ta	the cause of death?
uires that	d by	Renal Dise		ung in the ti	idenying ca	iuse give	n in Pait I.			s 2 🗆		
w requir	lete								24a. Was ar	,	24b. Were au	topsy findings available
The lav	Completed								autopsy perform	ned?_	prior to c death? 1 \(\sum \) Yes	ompletion of cause of 2□ No
ician: The	BeC	25. Was case referred to medical examiner?					26. Place	of Death	Check only one		Allenia .	
Physic this o	²	1, Yes 2 No H		R/Outpatien			4 🗆 1901		ne 5 Reside			ify)
ding I	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 28	3c. Injury Work'	at ? es 2 □ N		8d. Describe ho	w injury	occurred	
l or Attendi after death. Diractor: A	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - At hon	ne, farm, stre							Number or Ru	ra <i>l R</i> oute Number,
tal or	Cert	4 Homicide	building, etc. (Specify)						City or Town	, State)		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	edical	29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 ☐ Medical Examir	ician: To the best of my know ler: On the basis of examination and manner stated.	ledge, death on and/or inv	occurred a vestigation,	t the time in my opi	e, date and inion, deat	d place, a	and due to the ca	use(s) ar	nd manner as lace, and due	stated. to the cause(s)
To the within To the complex	Me	29b. Signature and title of certifier	2		29c.	License	number		29	d. Date	signed (Month	, Day, Year)
		Salvador	Mosta	20		1500	559	27		Aug	ust 2	6 2005
27		30. Name and address of person who co		4	Print)	2		- 1	ever!		,	1
			32. Registrar's Signatu	tospi-	tal	Dri	~/_	Ch	ever!	7,	MAY	land
St Regist	ate trar	31. Date file A (V) Gh, Day, Year)	Sleepe K	has	1.						•	

1. Decedent's Name (First, Middle, Last)

1	Physicia /Medic Examin	al .	Albert 4a Facility Neme (If not institution, give si	Harris treet end number)			4b. City, Town, or	August Location of Deet		Year 2005 of Death	01:35AM
	LAGIHIII	Ç1	Gladys Spellman S	nec. Hosp.	& Rehah	Ctr	Cha	verly			Coomesta
Ī	Funeral Director		5. Social Security Number 6. Sex 1 🔀		vrs. lest birthday) 84 Yrs.	If Under 1 Yea Months Days	r If Under 24 Hrs. s Hours Min.	8. Date of Bir (Month, Da	th ay, <i>Year)</i> 19, 1921	9. Birthp	George's place (State or Foreign nnessee
	and		Usuel Residence of Decedent 10a. Stete 10b. County	10c.	City, Town or Lo	cation					Od. Inside City Limits
	death with the Maryland ms 23a or 28a-f show r.must.be.notified at	to	Maryland Prince	George's			Lorgo				1 X Yes 2 □ No
	or 28s	Director	10e. Street end Number	George S		10f. Zip Code	Largo		10g. Citizen of	Whet Cour	ntry?
	23a o		500 S. Harry T	ruman Dr.,	#300		20774		Uni	ted S	States
		Funeral		Was Decedent Ever i Armed Forces?	n U,S. 13. \	Vas Decedent of Yes, specify Cu	Hispenic Origin? (S	pecify Yes or No o Rican, etc.)	- 14. Rad Bla	e - Americ	en Indian,
220	72 hours aftar natural', or ite deal Examine	<u>۾</u>	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		I□Yes 2∏ No	o Specify:		Specif	v: B]	Lack
ე ი	72 ho	Completed	15. Decedent's Education (Specify only highest grede	ation completed)	16e. Deced	ient's Usual Occi	upation e during most of wor ed)	kina	16b. Kind of B	usiness/In	dustry
V	within ene.	ğ	Elementary/Secondary (0-12)	College (1-4or 5+)	`life. L			9			
7	0 0 -	ပ္	12th 17. Father's Name (First, Middle, Last)			Sky Ca	ap 18. Mother's Nar	no (First Middle	Maiden Sumar	Priv	zate
	d be file antal Hyg ced othe c event,	o Be	William Harris				TO. MICHIGI STAZI				
3	shoul nd Me merk	۲	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	g Address (Stree	et and Number or Ru		e (Unkn		Code)
Ž	alth a		Cornelia W. Harr	is - Wife		-	rry Truman				•
ore,	of Has	Ì	20a. Method of Disposition		b. Place of Dispo			Date	20c. Location		
Ĕ	Page nent c		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	-	Cremate	1	8/29/05	C1	intor	n. MD
	omit.		21. Signature of Fune al Service Licenses	· A A		. Name and Add		Stewart			· · · · · · · · · · · · · · · · · · ·
0	207 2 2		Lown!	Thurand	TIL	4001 Be	enning Rd	, N.E.	Wash.,	DC 20	019
			23a. Pert1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the decause on each line.	leath. Do not ente	er the mode of dy	ying, such as cardiac	or respiratory a	rrest,	1	Approximate Interval Between
	Physician		V							and the same of th	Onset and Death
eriji i	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	ACUTE	MYOC	ARDIAL	INFA	RETION)	:	~1 6
	.4	P.	, south y	Due t	o (or as a conseq	uence of):					
	uted d ansit	Examiner	b .	END C.	TAGE o (or as a conseq	CONGE	STIVE	HEART	FAIL	URE	~ marty
ŕ	icate be executed physician and s the burial-transit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			uence ot):				1	
9	te be ysicla	cai	cause. Enter Underlying Cause (Disease or injury that initiated events	D EM EN	O (or as a consequ	vence of):					Years
0	* C	ysician/Medicai	resulting in death) Last		,	ŕ				1	
Õ	ha death certifice the attending pl ched for use as t	lan/	d.		_					1	
5	the atter	ysic	Part II. Other significant conditions conti	ributing to death but not	resulting in the ur	nderlying cause g	iven in Part I.	23b. Did	tobecco use co	ntribute to	the cause of death
	that the ded by	듄						1 🗆	Yes 2□ No	3 Prot	oably 4Å Unknow
ecords,	uiras 1 sign	d by						24a Was	an autopsy	24b. We	ere autopsy findings
5	w req	Completed							rmed?	ava	ailable prior to mpletion of cause deeth?
Ē	he la ta has aga 2	Eo						10	Yes 2.D Y No		Yes 2□ No
NI COL	an: 1 tiffical	Bec	25. Was case referred to medical				26. Place of Dea				163 2010
	ysici is ce direc	2	examiner? 1 ☐ Yes 2 No	spital: 1 Inpatient 2	□ ER/Outpetien	3□ DOA O	th	ome 5□Resid		er (Specif)	y)
5	ng Ph tter th meral		27. Manner of Death 1 S Natural 5 □ Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	28c. Inja			now injury occur		
2	andir eath. or: Ai	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2□No				
DIVISION	after d Direct Direct	Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	at home, farm, stre ecify)	et, factory, office	9	28f. Location (S City or Tox	Street and Numb vn, State)	er or Rura	l Route Number,
	To the Hospital or Attanding Physician: The law requiras that the within 24 hours after death. To the Funeral Director: After this certificata has been signed by completaly filled in by the funeral director, paga 2 should be data.	edicai C	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine	cian: To the best of my left: On the basis of exam and manner stated.	knowledge, deeth ination end/or inv	occurred at the t estigation, in my	time, date and place opinion, death occur	, and due to the rred at the time,	cause(s) and madate and place,	inner as st and due to	ated. the cause(s)
)	within To the	Σ	29b. Signature end title of certifier			29c. Licen	nse number		29d. Date signe	d (Month, i	Day, Yeer)
			W-2 We	y		C	0-1787	4	8-2.	2 -03	
			30. Name and address of person who com	npleted cause of death (I	tem 23a) (Type, I	Print)	BRENTWO	OD , N	10 20	722	-
	Sta			32. Registrar's Si				-) .			
H	Registra	ar	AUG 3 0 2005	us to A							
			_	# m							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2005

2. Date of Deeth

			For State Registrar	State of Ma		d / Depa		t of H	ealth a				n n	15	299	145
	Physicia /Medic	al	1. Decedent's Name (First, Middle, Last Will G Muc)	Hayer			imout				2. Date of Da Month AUGUST	ath Day	و ما	Year 2045	3. Time of 0.5 0	Death
7	Examin		4a. Facility Name (If not institution, give	7.2			4b. City,	_	Location o		•	4c. C	ounty of			
	Funoral		5. Social Security Number 6. Se		e (In yrs. Ia	st birthday)	If Under	1 Year	iSBUR If Under	24 Hrs.	8. Date of Bir (Month, Da	th		9. Birthple	ace (State or	r Foreign
	Funeral Director		146- 24-2300	M 203F	69	Yrs.	Months	Days	Hours	Min.	(Month, Da 11/24,			Alah		
	rland ow	1	Usual Residence of Decedent 10a. State 10b. County		10c. City,	, Town or Lo	cation							10	d. Inside Cit	y Limits
	a-feh uffect	ctor	Maryland Wicomic	xo	S	Salisb	ury								1 ½ Yes	2 No
	or 28	Dire	10e. Street and Number				10f. Zip					10g. Citize		nat Count	ry?	
	s 23a	eral	233 Dove St.	12. Was Decedent 8	Ever in 11 C	112.1		801	ionanio Orie	ain? (Sn	noity Vac or No		SA	- America	o Indian	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other treumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 XN If Yes, Give Year or Dates:			Yes, spec		Specify:	, Puerto	ecify Yes or No Rican, etc.)			White, e		
S O	72 ho	eted	15. Decedent's Edu (Specify only highest grad	ucation le completed)		16a. Dece	kind of woi	k done o	lu <i>rina</i> most	t of worki	ing	16b. Kind	of Busi	iness/Ind	ıstry	
121	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		oo not us ervis)			Ele	ctro	nics		
2 2	illed Hygid other	Be Co	17. Father's Name (First, Middle, Last)			Ծաք	ELVIS	OL	18. Mothe	r's Name	(First, Middle,					
ylar	Menta Menta arked atic ev	ToE	Willie Butler						Kati	e M.	Olive	<u> </u>				
Maryland 21215-0036	d 2 shoth and 7 is m		19a. Informant's Name/Relationship (T) Pamela V. Hayer/o	•							Al Route Numbe	-		tate, Zip (Code)	
	f Heall fem 2 other		20a. Method of Disposition	augricer	20b. Pla	ace of Dispo	sition (Nan	ne of	-		ry, MD			ity or Tow	m, State	
E O	Page: nent o ant: If		1 Burial 2 Cremation 3 ☐ P '4 ☐ Donation 5 ☐ Other (Specify)		Mar	ole Gr	ove C	emet	ery	8/30	/05	Hack	ensa	ck,	NJ	
Baltimore,	permit. Departr Import		Signature of Funeral Service Licens	mmore	CFS	P 3	ui Sn	OW H	111 K	(Cl	me Proi Salisbu	irv. i	onal MD 2	. Ass	ociati	ion
п			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused ne cause on each lir	the death.	. Do not ent	er the mod	e of dying	g, such as	cardiac o	or respiratory a	rrest,		1	Approximate interval Betwood	veen
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a			CVD									ens
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	₽ ≒	iner	Sequentially list conditions, if any, leading to immediate cause. Error underlying Cause (Disease or injury	Due to (or as	a consequ	ence of):										
_	le be executed ysician and e burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequ	ence of):										
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89			JE SELVILE	V.					-		10	- 1				
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal	death 3	Ectopic pro Other (sp.					23	d. Date Month	of deliver		'ear
۳.	s that ined by	y Ph	Part II. Other significent conditions co	ntributing to death be	ut not resu	tting in the u	nderlying ca	ause give	en in Part I.		23e. Did t	obacco us	e contrib	oute to the	cause of de	eath?
ords	w requires that been signed k should be deta										10	Yes 2 💭	MO 3	Proba	bly 4 □U	nknown
ecc	e lawr has be ge 2 sh	Completed									24a. Was autor	sy	pri	or to com	sy findings a pletion of ca	available tuse of
alF	ysician: The l is certificate ha director, page										1 Yes			ath? Yes 2	!□ No	
<u>=</u>	rsicia s certi directo	To Be	25. Was case referred to medical examiner?	Hospital:	nt 2 🗆 E	ER/Outpatier	nt 3□ DO	A Othe	4		n <i>(Check only c</i> me 5 ☐ Resid		————	(Specify)		
0			27. Manper of Death	28a. Date of Inju. (Month, Day		28b. Time o		Bc. Injury Work			28d. Describe					
sior	Attsnding Physician: r death. ector: After this certific by the funeral director.	catlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				М	יםי	Yes 2 🗆 l	No						
Division of Vital Records,	ital or Att urs after d ral Direct	Certification:	4 Homicide determined	28e. Place of Injubus	c. (Specify,)					281. Location (: City or To	vn, State)				ber,
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical Exam one)	rsician: To the best of iner: On the basis of and manner sta	examinati		vestigation,	in my op	oinion, deal		ed at the time,	date and p	lace, an	id due to t	he cause(s)	
	To To con	2	29b. Signature and title of certifier	llsim	0.0-	0 1	29c		number	Ca		29d. Date				
•	1/3		30. Name and address of person who c	USHA ompleted cause of d			Print)	70	5735	7		Hugo	NST	26"	2005	
	· Pa		1415.5	DIVISION S	T SA	nKBUI	en M	אבנו	104							
50	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signat	ure			7							
DH	Registr	_	HUU & 0 2	32. Registra	de .	H. A	perli	,								- 4
						-										

ORIGINAL

		1	1 - For State of Ma	aryland / Depa	artment of F			iene 2005	29946
E	Physicia		Decedent's Name (First, Middle, Last) Mary Dorothy Hayes				2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		Mary Dorothy Hayes 4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death	Kotkuber	4c. County of Deat	
ī	Funeral Director		Washington County Hospita 5. Social Security Number 6. Sex 1 □ M 2 💢 F	o (In yrs. last birthday) Yrs.	Hage If Under 1 Year Months Days	STOWN If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 28,	Washin 9. Birtl Co 1926 M	gton place (State or Foreign untry) ary land
	pue A		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ecation		, une 20,	1,720	10d. Inside City Limits
	the Maryis 28a-f eho	ector	Maryland Washington 10e. Street and Number		gerstown 10f. Zip Code		1/	Og. Citizen of What Co	1 ☐ Yes 2 🕅 No
	Maith 13a or	al Dir	17221 Amber Drive			1740		_	SA
036	parmit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Heelth and Mental Hygiena. Department: If term 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other treumatic event, the Modical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent I Amed Forces? 1 Yes, Give Year or Dates:	40		lispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	rican Indian,
21215-0036	thin 72 ho a. an "natur Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	(Give		during most of workii d)	ng	16b. Kind of Business/	
N	filed w Hygier other th		12 17. Father's Name (First, Middle, Last)	Dayo	are Prov	ider 18. Mother's Name	(First, Middle, N		care
	Ald ba	To Be	Charles A. Grant				McDon	,	
Mary	2 should and Men is marke reumatic		19a. Informant's Name/Relationship (Type, Print)			and Number or Rura	Route Number,	City or Town, State, 2	îp Code)
e, Z	1 and Heelth em 27 other tr		Terry Hayes - Son 20a. Method of Disposition	111 20b. Place of Disponsional Commetery, creat		Ave. Dune		W Jersey 20c. Location - City or	08812 Fown, State
altimore,	Pages nent of int: If It iry or o		XXBurial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify)			!		agerstown.	
Balti	parmit. Departm Importe any Inju		21. Signature of Funeral Service/Licknisee	08	borned fruit	sera dity	, P.A.	liamsport,	
			Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir Immediate Cause (Final	10.		_	r respiratory arre	est,	Approximate Interval Between Onset and Death
	mysician /Medical		disease or condition a. Corbra	a consequence of):	callet, cas	Romei			12 Lay
	Examiner		Sequentially list conditions, if any, leading to immediate Due to (or as						
	uted I Insit	Examine	Cause. Enter Underlying Cause (Disease or injury	a consequence of):				9	
8760,	death certificate be executed e attending physicien and d for use as the burial-transit	ai Exa	that indiated events resulting in death) Last C Due to (or as	a consequence of):					
687	rtificate ng phys as the	Medic	IF FEMALE:						
0	the cha	Physiclan/Medical	23b Was decedent pregnant 23c. If yes, outcome	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
Vital Records, P	es be	by	Part II. Other significant conditions contributing to death be Deluglication & hygovolomic	ut not resulting in the u	Inderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to s 2 ☑No 3 ☐ Pro	
eco	aw as b	Completed	1 neomonios		1		24a. Was ar		topsy findings available ompletion of cause of
al B	The page		Chronis alstantive policon	y design				□No 1 □ Yes	2□ No
VII.	Physician: this certific ral director.	o Be	25. Was case referred to medical examiner? 1 Yes 2 Hospital: 1 Ippatie	ent 2 ER/Outpatier	nt 3 DOA Oth	er: 4 Nursing Hor		nce 6 □Other (Spec	ufv)
		on: T	27. Manner of Death 28a. Date of Inju 1	ry 28b. Time o	f 28c. Injur Wor	y at k?		w injury occurred	
=	or Attendition (fer death	ertification;	2 Accident investigation	ury - At home, farm, str c. (Specify)		Yes 2 No	28f. Location (Str City or Town	eet and Number or Ru , State)	ral Route Number,
_	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical Ce	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of the basis of and manner state.	f examination and/or in	h occurred at the tin vestigation, in my o	me, date and place, a pinion, death occurre	and due to the ca	use(s) and manner as ite and place, and due	stated. to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier		29c. Licens	e number		d. Date signed (Month	
			"harplik , M	<u>D</u>		1040	0	9-01-200	<u> </u>
ځH	1-5		30. Name and address of person who completed cause of d DANNY CONTY, 322 C. HAS	- 100 m	1411	GERSTOW.	N. M.	21740	
	Sta Regista		31. Date filed (Month, Day, Year) SEP U ≈ 2005 32. Registr.	ar's Signature	perse				

				d / Department of Health and I Certificate of Death	Mental Hygie	
	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last) WALTER G. HOXTER 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		Day Year 3. Time of Death 24 2005 1658 M
	Funeral Director		UNVESTY OF MARYLAND MOS. 5. Social Security Number 218-50-1966 Usual Residence of Decedent	ast birthday) Yrs. BALTIMORE BALTI	8. Date of Birth (Month, Day, Y	9. Birthplace (State or Foreign Country) 1948 MD
	he Maryland 28e-f show offitted at	Director	10a. State 10b. County 10c. City MD QUEEN ANNE S STE	, Town or Location VENSVILLE		10d. Inside City Limits 1 ☐ Yes 2 No
	a or 2		10e. Street and Number 330 MAIN STREET	10f. Zip Code 21666	-	. Citizen of What Country?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: if Item 27 is marked other than "naturel", or Items 23a or 28e-f show any follury or other treumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 2 Widowed 4 Divorced 12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			14. Race - American Indian, Black, White, etc. Specify: WHITE
21215-0036	ithin 72 ho ne. nan "natur Nedical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)	king 16	b. Kind of Business/Industry
2	led w tygier her th		8	CRANE OPERATOR		CONSTRUCTION
Maryland	should be find Mental H marked ott umatic ever	To Be	17. Father's Name (First, Middle, Last) WALTER HOXTER 19a. Informant's Name/Relationship (Type, Print)	NANCY (
ā Z	d 2 st th and t7 is n treun		PATRICIA BACON/DAUGHTER	19b. Mailing Address (Street and Number or Ru 147 WEST GOLDFINCH LAN		
	t and Health tem 27 other tr		20a. Method of Disposition 20b. P	ace of Disposition (Name of		c. Location - City or Town, State
ē	Pages nent of ant: if its ary or o		1 A Buria: 2 Cremation 3 Hemoval from State	ometery, crematory or other place) VENSVILLE CEMETERY 08/2	9/2005 5	TEVENSVILLE, MD
Baltimore,	permit. F Departm Importer any injur		21. Signeture of Funeral Service Licensee	22. Name and Address of Facility	& NEWNAM	FUNERAL HOME, P.A.
THE PARTY	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Li [L pence of):	or respiratory arrest	Approximate Interval Between Onset and Death Queeks
3760,	icate be executed physician and s the burial-transit	Ilcal Examiner	cause. Enter Underlying Cause Cisease of right that initiated events resulting in death) Last C. Due to (or as a consequence of the consequence	ience of):		
.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnant 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
Δ.	v requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resu	Iting in the underlying cause given in Part I.		200 use contribute to the cause of death?
Vital Records,		Completed	Atrial Fibrilation		24a. Was an autopsy performe	24b. Were aulopsy findings available prior to completion of cause of death? No 1 Yes 2 No
Ž.		Be	25. Was case referred to medical examiner?	Othors	th (Check only one)	
ō	ding h. After fune	ıtlon: To	27. Manner of Death 1 Manual 5 Pending 2 Accident Investigation 1 Month, Day Year)	28b. Time of 28c. Injury at Work?	ome 5 ☐ Residence 28d. Describe how	e 6 Other (Specify) injury occurred
Division	ei or Atten s after deat i Director: id in by the	Certification:	3 □ Sweeds 6 □ Could not be	me, farm, streel, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	To the Hospitei or At within 24 hours after o To the Funerel Direct completely filled in by	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examinat and manner stated.	wledge, death occurred at the time, date and place ion and/or investigation, in my opinion, death occu	, and due to the caus rred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To the complete	M	29b. Signature and title of certifier	29c. License number P16767	29d.	Date signed (Month, Day, Year) AUG 34 2005
1	eth		30. Name and address of person who completed cause of death (Item Keri Jacobs, MD, 22 S. G	reene Street, Shite N3E	10, Balti	more, MD 21201
	Sta Registr	- 5	31. Date filed (Month Aug 6 2 6 2005 32. Registrar's Signal	& freels		

THOMAS HARDING 05-06072 RKD

_	Unp for State Registrar	Please end item 23	Type or Print in a,27,28a f.pen State of Maryl	and / Dep	delible ink partment of l ertificate of	Health and	Mental Hygi	Are Legible. ^{ene} 2005 _{g. No.}	2994
Physician	1. Decedent's Name Thoma:	_					2. Date of Death Month SEPTEMBE	Day Year	3. Time of Death 7:05A.
/Medical Examiner	1100 POPL	AR STREET			FREDER.		th	4c. County of Dea	th C
uneral irector	5. Social Security No. 216–48–71 Usual Residence of	76	xM 2□F 57	Yrs. last birthday Yrs.	Months Days			Year) Co	thplace (State or Foreignets) yland
a-f ahow	10a. State Maryland	10b. County Frederic		City, Town or I					10d. Inside City Limi 1 ☑ Yes 2 ☐ N
sa or 28 at be no ai Dire	10e. Street and Num 1100 Pop	_{lar} Stree	et		10f. Zip Code	21703	10	g. Citizen of What Co USA	ountry?
item 27 is marked other than "natural", or itema 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at other traumatic event, the Medical Examinar must be notified at other traumatic event, the Medical Examinar must be notified at	11. Marital Status 1 Never Marrie 3 Widowed		12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	in U.S. 13	. Was Decedent of If Yes, specify Cul		Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit	
it, the Medical E		15. Decedent's Edify only highest gra	ucation de completed)	16a. Dec	edent's Usual Occu re kind of work done DO NOT use retire	pation during most of wo	orking 1	6b. Kind of Business	/Industry
r than	Elementary/Secon	ndary (0-12)	College (1-4or 5+)		ner/Opera			Restaura	nt
arked oth atic event	17. Father's Name (First, Middle, Last)	Harding			18. Mother's Na	ame (First, Middle, M Mab		obs
traumat	19a. Informant's Na Patricia	me/Relationship (7	ype, Print)					City or Town, State, MD 21703	Zip Code)
y or other	20a. Method of Disp	osition	Removal from State	b. Place of Dis	position (Name of ematory or other pl.	ace)	Date 2	oc. Location - City or	
Important: If its any injury or of once.	21. Signature of Fu		1 -		22. Name and Addi	ess of Facility	Stauffer F	Tuneral Ho lerick, MD	me, PA
/sician ledical aminer	shock, or hea Immediate Cause (disease or condition resulting in death)	nt failure. List only Final n n n n n n n n n n n n n n n n n n	a. Contact Gurs Due to (or as a cor	shot Wound resequence of):	nter the mode of dy	ing, such as cardia			Approximate Interval Between Onset and Death
E CE		Last	Due to (or as a cor	nsequence of):				11	
d by the ettending physic detached for use as the b	IF FEMALE: 23b. Was decedenged in the past 12 1 □ Yes 2 □ 9 □ Unknown	months?	23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	B Ectopic pregnan	су		23d. Date of de Month	olivery Day Year
e pe	Tuk ii. Guidi digilii	icant conditions o	ontributing to death but no	t resulting in the	underlying cause g	iven in Part I.	23e. Did tob	acco use contribute t	o the cause of death
page 2							24a. Was ar autopsy perform Yes 2	v prior to	utopsy findings avail completion of cause s 2 \(\square\) No
rector	25. Was case refer examiner?	1.5	Hospital:			ther.	eath (Check only one		CODIT
Director: After this certific in by the funeral director,			28a. Date of Injury (Month, Day Yea	2 ER/Outpat 28b. Time Injury 7:00	of 28c. Inj	4 🗀 Huising	28d. Describe ho	nce 6 N other (Spow injury occurred	ocity SCENE
Director: After in by the funera	3 Suicide 4 Homicide	6X Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm,	street, factory, office		28f Location /Str	reet and Number or For State) 1100 PO	Pural Route Number,

To the Hospital or Atter within 24 hours after dea To the Funeral Director, completely filled in by the

29b. Signature and title of certifier

31. Date filed (Month, Day, SEP 0 8

29c. License number

1 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

O.C.M.E.

SEPTEMBER 6,2005

leted cause of death (Item 23a) (Type, Print)

Residence

200 Registra Signature

111 PENN STREET BALTIMORE, MARYLAND 21201

Frederick, MD

State Registrar

Medical Certifi

29a. Certifler (Check only one)

05-6008 B.K.S FRANKLII

			CKSON For Amend Item State Registrar 1. Decedent's Name (First, Middle).		001	inoute of	DOUIN'S I	2. Date of Death		3. Time of Death	
	Physicia		FRANKLIN D	•				Month SEPT.	Day Year 2. 2005		
	/Medic Examine		4a. Facility Name (If not institution, LAUREL REGIONAL			4b. City, Town, o	r Location of Death		4c. County of Dea	ath	
	Funeral Director		578-78-9708	. Sex 7. Age (In yi	rs. last birthday) 60 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,	Year) 9. Bi 7, 1945 Was	nthplace (State or Foreignountry) Shington, D	
2	yland how		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limit	
	28a-f e	Director	Maryland Montgo	omery	Bur	tonsvill	е	10	Cisina at Mina C	1 ∑ Yes 2 □ N	
	23 or	급	3907 Blackburn	Lane #33			866		g. Citizen of What C USA	ountry?	
36	permit. Pages 1 and 2 should be lied within 72 hours after deen with the maryland beneficially of Heeling and Mental Hyghest than "naturel", or teme 23e or 28e-f ehow eny injury or other treumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 💢 Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1		Vas Decedent of H f Yes, specify Cubi 1 ☐ Yes 2 1 No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh Specify:	encan Indian, ite, etc. Black	
Baltimore, Maryland 21215-0036	nature dical E	eted !	15. Decedent's (Specify only highest	Education	16a. Deced	ient's Usual Occup kind of work done OO NOT use retired	ation during most of wor	king	6b. Kind of Busines		
2121	giene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		es Repres			Priv	ate	
9	ital Hygid other	Be	17. Father's Name (First, Middle, La					ne (First, Middle, M	,		
Z	marke	၉	Alexander 19a. Informant's Name/Relationship	Jackson, Sr.	19b Mailin	ng Address /Street	Lucil.		kins City or Town, State,	Zin Code)	
Ma	elth ar		Joann Jackson	Wife	3907	Blackbur:	Lane #3		nsville. N		
ore	iges 1 of He if it in or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	Li callovariioni State	cemetery, cren	sition (Name of natory or other plac	ce)	Date 2	0c. Location - City o	r Town, State	
E E	ortant: Pa		4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service □		ncoln Me	em. Cemet . Name and Addre	ery 9/10	/2005	Suitland	l, MD	
ă	Deperiment of the control of the con			SHE	140	or peillir	пу коаа.	Mr. washi	ral Servi	ce, Inc. 20019	
			23a. Part1. Enter the disease, or o shock, or heart failure. List or tmmediate Cause (Final							Approximate Interval Between Onset and Death	
	Physician /Medical Examiner		disease or condition resulting in death)	a. Cardiac Ar		During	rnysicai	Altercat	lon		
Н		P.	Sequentially list conditions,	b. Due to (or as a cons	equence of):						
	nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c							
-	sicle bu	cal	resulting in death) Last	Due to (or as a cons	equence of):						
DIVISION OF VITAL RECOIDS, F.O. BOX 60	Attending Physicien: The law requires that the death certificat death.	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of prec 1 ☐ Live birth 2 ☐ Fo 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	elivery Day Year	
5	ss that gned by se deta	by Ph	Part II. Other significant condition					23e. Did tob	acco use contribute	to the cause of death?	
;	w requires that been signed to should be det	eted	Hypertensive At	herosclerotic (Cardiova	scular D	isease	1 Te	s 2□No 3□F	robably 4 Onknow	
	The taw ite hes b	отр						24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of s 2 \subsetential No	
	cien: ertifice ector, p	Be	25. Was case referred to medical examiner?			To		th Check only one		2 2 110	
;	r this o	5.7	1 XYes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury		4 Li Nursing n	ome 5 Resider	nce 6 Other (Spenior)	ecify)	
	To the Hospitel or Attending Physicien: The law within 24 hours elter death. To the Funerel Director: After this certificate hes completely filled in by the funeral director, page 2.	Certification:	1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no determin	Subject :	in physica	al altercat					
2	urs efter rel Dir										
	Phosp 24 hou Fune etely fi	Medical	29a. Certifier 1 ☐ Certifying (Check only one)	Physician: To the best of my k caminer: On the basis of exami- and manner stated.	knowledge, death ination and/or inv	n occurred at the tir vestigation, in my o	ne, date and place pinion, death occu	, and due to the car rred at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)	
	vithin 2 To the I	Me	29b. Signature and title of certifier	ronica-Pa	lO.L.	29c. Licens	e number C.M.E		d. Date signed (Mon SEPT. 3, 2		
			30. Name and address of person w			•	BAT TTMOE	RE MARYLAI	NTD 21201		
			SHOW IN THE PARTY OF THE PARTY	I I I A K IVIN	TIT LIMIN	OTIVITIES .	DUTITION	TT TATE THE	VU 41401		
	Sta Registra		31. Date filed (Month, Day, Your)	32. Begistrans Sig		das septiment	DAULITION		ND ZIZOI	-	

State of Maryland / Department of Health and Mental Hygien200529950 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2005 08 12:40 PM Mable Corena Jones /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4950 Skinners Run Road Hurlock Dorchester If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number '. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F **Yrs** April 16,1943 Director 214-42-8411 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location in then "netural", or items 23e or 28e-f show the Medical Exacting must be notified at 10d. Inside City Limits 1 Yes 2 No Directo Dorchester Maryland | Hurlock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Items 23e and njury or other treumatic event, the Medical Experience 23e and njury or other treumatic event, the Medical Experience 23e and njury or other treumatic event, the Medical Experience 23e and njury or other treumatic event, the Medical Experience 23e and njury or other treumatic event, the Medical Experience 23e and njury or other treumatic event, the Medical Experience 23e and njury or other treumatic event, the Medical Experience 23e and njury or other treumatic event, the Medical Experience 23e and njury or other treumatic event, the Medical Experience 23e and njury or other treumatic event. 4950 Skinners Run Road 21643 USA by Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: Specify. 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Packer Cold Water Seafood 11 Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William Howard Jones Elsie Emily Butler 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Hall / Daughter 27502 Sandpeeble Drive, Millsboro, Delaware 19966 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Dopation 5 □ Other (Specify) coppins Church Cem. 08-30-2005 Preston Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home SU 516 S. Maine Street, Hurlock, Maryland 21643 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** estor /Medical Due to (or as consequence of): **Examiner** cars Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the human transmit. Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 🗍 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Miknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Strik planner page 2 s 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) C6002831 6 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) HOFFIN AN FEDERALIBURG MD - CHOPPANIC COMMUNITY HEALT ASSOUR PA-9 31. Date filed (Month, Day Year) 1 2005 32. Registrar's Signature Sale you

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death ZU Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** MARY FRANCES JEWELL 12:00 PM AUGUST 24 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1105 MAIN STREET STEVENSVILLE QUEEN ANNE'S If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F 91 Yrs. Director 214-34-8423 25, MD 1914 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits rei', or iteme 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Directo QUEEN ANNE'S STEVENSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1105 MAIN STREET 21666 USA Funeral filed withIn 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE Specify Specify: Completed by 3 X Widowed 4 ☐ Divorced 'naturei' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 CLERK **GROCERY STORE** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Depertment of Health and Mental Hy Importent: If Item 27 is marked oth any linjury or other treumatic event 2008: Be ဥ MARION NORMAN TANNER LILLIAN VICTORIA CARTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES C. JEWELL/SON 1816 ST. MARY'S RD., CHESTER, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE CEMETERY 08/30/2005 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine mediate Cause (Final disease or condition)

Author My OCA DIA (Amount of the condition) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** wohl DERIOS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examine burial-transit certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 ettending physicien for use as the buria Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown detached ed by the 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by fiscillation. Atria 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital of or Attending Physicien: after death. Director: After this certifice 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funerel I Hospitei 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) the 29b. Signature and little ertifie 29c. License number 29d. Date signed (Month, Day, Year) DV0294-2000 s person who completed cause of death (Item 23a) (Type, Print) 10 KIC ERIC HERMANSEN, M.D., 2108 DIDONATO DRIVE, CHESTER, MD AUG 2 6 2005 31. Date filed (Month, 32. Registrar's Signature State Registrar eve & fresh

State of Maryland / Department of Health and Mental Hygiene 29952 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** A. John son Evelyn 8:40 P M 20 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chestertown
If Under 1 Year | If Under 24 Hrs. Nursing Home
7. Age (In yrs. last birthday) Manor Kent Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 💢 F 220-32-8124 Director MD Usual Residence of Decedent death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itams 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No Kent Bockhall Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Brittany Apts 204 usa Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ş Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event QNGS. illian Unknown Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Burke Fairlee Rd Chestertown, MD Joyce cousin) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 8127105 Rich Neck 4 □Donation 5 □ Other (Specify) Hall 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith FH - Butlertown, MD Jummle Maw Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Artero Sclovetic Cardio Vascular Diseaso **Physician** Leaks /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine signed by the attending physician and d be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy med? 20 No this certificate 2□ No 1 Yes 1 Yes Director; After this certific d in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funarail 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Clesterta Veil Stoddard 31. Date filed (Month, Day, Year) 32. Registra Signature State AUG 2 9 2005

Registrar

			1 - For State Registrar	State of Marylan		artment of F			ene2005	29953
	Physici /Medic		Decedent's Name (First, Middle, La	Ralph Will	iam K	ing, Sr		2. Date of Death Month September		3. Time of Death 2:30 A M
	Examin		4a. Facility Name (If not institution, giv 56 West Baltimo:			4b. City, Town, o	Location of Deat		4c. County of De	ath
Ī	Funeral Director		5. Social Security Number 6. S 214–28–7375	ex 7. Age (In yrs.	last birthday) 2 Yrs.	If Under 1 Year Months Days			rgar)	inthplace (State or Foreign Country) ryland
	aryland ehow	7	Usual Residence of Decedent 10a. State 10b. County Maryland Carroll		y, Town or Lo					10d. Inside City Limits 1 Yes 2 □ No
	with the M a or 28a-f	Director	10e. Street and Number 56 West Baltimo	-	aneyto	10f. Zip Code 21787			g. Citizen of What C	Country?
036	be filed within 72 hours after death with the Maryland tal Hygiene. dother than "natural", or Itams 23a or 28a-f ehow evant, the Medical Examiner must be notilled at	by Funeral	11. Marital Status 1 □ Never Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes ※ No	ispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No-	14. Race - An Black, Wh Specify: Wh	terican Indian, ite, etc.
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aryland	should be filed nd Mental Hygi markad othar imatic evant, II	To Be C	17. Father's Name (First, Middle, Last, Alvah Joseph K		me (First, Middle, Ma eth Marie	,				
≥	d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationship (Ralph King, Jr.	**				ura/Route Number, Baltimor		
altimore,	Pages nent of ant: If i		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif		2005 F	inksburg,				
Balt	permit. Pag Department Important: I any injury o	[21. Signature of Funeral Service Licer	. Purvi	13	Name and Addre	ss of Facility Sk altimore	iles Fune Street	ral Home Taneytown	, Md. 21787
	Physician /Medical		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Mitst	ic L		g, such as cardia	c or respiratory arres	it,	Approximate Interval Between Onset and Death
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,	cate be executed physician and the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conseq.	uence of):					
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Il Records,		Completed						24a. Was an autopsy performe	24b. Were a prior to death?	
r Vital	Phyeiclan: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 DOA Oth		ath <i>Check on one</i> dome	ce 6 TOther (Sp.	acify)
o uo	Jing After fune		27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Work	at at	28d. Describe how		,
Division of	al or Attendi s after death. Il Diractor: A id in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	et and Number or F State)	lural Route Number,
	To the Hospital or Ati within 24 hours after d To the Funeral Diract completely filled in by	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause of the								s stated. e to the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier Balak Im	and Do	number	39 9/9/2005 34 Meel. Ctr; westminster, MD				
_	Ø		30. Name and address of person who Babak Inan	completed cause of death (Item	23a) (Type,	Print)	Hights M	red. Ctr	; hestmi	nskr, MD 21157
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 4 2	32. Jegistrar's Signa	ture !	enti				

		-	For State Registrar	State	of Marylar		artment of F tificate of		Mental Hy	/giene Reg. No.	005	29954
	Physicia		1. Decedent's Name (First, Middle, Last)				1.0	2. Date of D Month	Day	Year	3. Time of Death
	/Medic	al .	Mary A						August		2005	0510 A ^M
	Examin	er	4a. Facility Name (If not institution, give				4b. City, Town, o		ath	4c. (County of Death	
			Future Care Cant 5. Social Security Number 6. Se		7. Age (In yrs.	la et hirthday)	Baltin	IOTE	rs. 8. Date of B	irth	Q Rieth	place (State or Foreign
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			Usual Residence of Decedent									
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	8a-f s	cto	Maryland		Ba	1timor						1 X Yes 2 □ No
	with th	Dire	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Cou	intry?
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ထ	be filed within 72 hours after death with the Maryland tall Hyglene. id other than "natural", or items 23a or 28a-f show event, the Modral Examinet must be notified at	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed F 1 ☐ Yes	orces? 2 🔯 No		Was Decedent of H	an, Mexican, Pue	erto Rican, etc.)		Black, White	
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ary	s t and 2 should t Health and Men item 27 le marke other traumatic	-	19a. Informant's Name/Relationship (7)	ype, Print)		19b. Mailir	ng Address (Street	and Number or i	Rural Route Num	ber, City or	Town, State, Zi	p Code)
	ss t and 2 of Health a item 27 le		Robert M. Koch/S	on		2725	Foster A	venue, B	altimore	, Mar	yland 2	1224
ore	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal fron		Place of Dispo cemetery, crer	sition (Name of natory or other pla	ce) Sej	ptember	20c. Loc	ation - City or T	own, State
Ë	Pag tment tant: jury c		* 4 Donation 5 Other (Specify)			ft Cemete	ry 3,	2005		ood, Pe	nnsylvania
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Sign ture of Funeral Service Licens	the	les	H:	Name and Addre icks Home 03 W. Sto	ss of Facility for Fu ockton S	nerals, treet, E	P.A. 1kton	, Maryl	and 21921
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	/Medical Examiner		resulting in death)	Due to	o (or as a conse	quence of):	10	CUN				140
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	ficate be executed physicien and is the burial-transit	Examine	Cause (Disease or injury that initiated events	c	. H	SPERT	Kyun					
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	0		30. Name and address of person who		4	- mag _{man}		n Scalia		•		
			31. Date filed (Month, DOF) n 1	2005	Registrar's Sign	lature 4-	Sports) 5	4224		·	
	Sta Regist		JEF (), 1	. 4003-	Meseus	J.F.	Gode					

State of Maryland / Department of Health and Mental Hygiene 2005 29955 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 26,2005 Physician 12:50 PM Shirley Η. Kramer /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Manor Care Potomac Montgomery Potomac If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct.14,1941 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** Days Hours California 1 M 28 F 561-56-5639 63 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23s or 28s-f show traumatic event, the Mudical Examiner must be notified at X□Yes 2□No Director Montgomery Md. Potomac 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 10714 Potomac Tennis Lane 20854 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 0. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ② No Specify: Specify: ģ 3 Widowed 4 Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 18b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than Medical Researcher Medical Field permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If tiem 27 is marked oth ery injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be June Hinkley Bernard Hyink 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Zach Kramer/Son 2257 Hollyridge Dr., Los ANgeles, Cal. 20068 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 □Donation 5 □ Other (Specify) Metropolitan Crematory 8-29-05 ALex., Va. 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., NW., Washington, DC 20007 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, x, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death stack, or heart failu atival Sclewis Amyotrophic
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1 Yes 2 No Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Hinknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate 1 Yes 22 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1-Natural 5 Pending Injury after death.

Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funeral Dire 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 00054566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sucilia Blogas 120 A East 10 Makeed, See h 230, TOCORON, MD212 PG 32 Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 30 Registrar

			For State Registrar	State of	Marylan		irtment of I tificate of		Mental Hy	giene Reg. No.2		29956
	Physici		Decedent's Name (First, Middle, L LYUBOV	ist)		КОҮ	FMAN		2. Date of De Month AUGUST	Day	Year 005	3. Time of Death 9:40 P
	/Medio Examin		4a. Facility Name (If not institution, gi		nber)			or Location of De	ath		ounty of Death	
	Funeral Director		213-27-1667	Sex 1□M 2∏xF	7. Age (In yrs. I 51	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H		ıy, Year)		place (State or Foreign htry) BAIJAN
	permit. Peges 1 end 2 should be filed within 72 hours efter death with the Marylend Department of Health and Mental Hyglane. Important: if item 27 is marked other than "natural; or iteme 23a or 28a-f show any injury or other traumatic event, the Mudigal Example must be notified at ance.	ai Director	Usual Residence of Decedent 10a. State 10b. County MARYLAND MONTGO 10e. Street and Number 10606 SAWDUST CI		10c. City	y, Town or Lo	ROCKVIL 10f. Zip Code	LE 20850)	10g. Citize	n of What Cour	•
900	ours efter deat rai', or iteme? Exeminar ou	by Funer	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ◘ Divorced	12. Was Dece Armed For 1 Yes If Yes, Giv Year or Da	2∭ No e		Vas Decedent of I f Yes, specify Cub		(Specify Yes or No erto Rican, etc.)		. Race - Americ Black, White, pecify: WH	
21215-0036	od within 72 ho giane. er than "natu er than "natu	Completed	15. Decedent's l (Specify only highest g Elementary/Secondary (0-12)		-4or 5+)	(Give life. L	lent's Usual Occup kind of work done OO NOT use retire AGE INST	during most of w	vorking		of Business/In	•
Maryland	ould be fite Mental Hy arked oth	To Be (17. Father's Name (First, Middle, Las NUSIN KOYFMAN	t)					ame (First, Middle		umame)	
, Mar	end 2 she ealth and m 27 is m		19a. Informant's Name/Relationship GREGORY KARASIK/			10606	SAWDUST		Rural Route Numb	LE, M	ARYLAND	20850
Baltimore,	ment of H		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		State	emetery, cren	sition (Name of natory or other pla MORIAL G		Date 23/2005		MARYL	
Ball	permit Depart Impor any in		21. Signature of Funeral Service Lic	Stot	tlemy	es D	I/O_ROCK	-GOLDBEF VILLE PI	RG MEMORI KE, ROCK	VILLE	APELS, MARYL	AND 20852
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or co shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any leading to immediate	a. OVAI	RIAN CA or as a consequence or a consequence or a consequence or as a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequenc	NCER uence of):	er the mode of dyl	ng, such as card	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
,0928	ficate be executed physician and s the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):						
.O. Box 6	death certii e ettending id for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		irth 2 ☐ Feta ant at time of d	Ideath 3	Ectopic pregnand Other (specify)	у		23	d. Date of delive Month	ery Day Year
rds, P	sign sign d be	by	Part II. Other significant conditions	contributing to de	eath but not res	ulting in the u	nderlying cause gr	ven in Part I.		obacco use Yes 2🔀		ne cause of death?
Vital Records,	The law ate hes b page 2 s	Completed							24a. Was auto perfo 1 Yes		prior to condeath?	psy findings available impletion of cause of
of	Attending Physician: Th r death. sctor: Atter this certificate by the funeral director, pag	ation: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒No 27. Manner of Death 1 ☒Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of (Mont	npatient 2 🗆 of Injury th, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Inju Wa	her: 4 Nursing	Home 5 X Resi 28d. Describe	dence 6 [y)
Division	ei or Attends eiter deatl	Certification:	3 Suicide 6 Could not 4 Homicide determine	208. Place	of Injury - At ho ng, etc. <i>(Specif</i>	ome, farm, str y)	eet, factory, office		28f. Location (City or To	Street and I wn, State)	Number or Rura	l Route Number,
	To the Hoapitei or Attent within 24 hours effer deati To the Funerel Director; completely filled in by the	edical (29a. Certifier 1 X Certifying (Check only one)	aminer: On the ba	best of my kno asis of examina ner stated.	wledge, death	occurred at the treestigation, in my	me, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) ar date and p	nd manner as s lace, and due to	tated. the cause(s)
)	To the 2 vithin 2 to the 1 complet	Me	29b. Signature and ntile of certifier 30. Name and address of person wh	o completed caus	C C Sie of death (Item	23a) (Tyne	29c. Licen D29		1		signed <i>(Month,</i>	
	Sta	ate	DR. CHARLES R. BO 31. Date filed (Month, Day, Year)	DICE, 103	301 GEO	RGIA A	VENUE #20	O5, SILV	ER SPRING	G, MAF	RYLAND	20902
	Regist			005 And	we to	ature 603						

		1. Decedent's Nar	ne (First, Middle, La	ast)						1	2. Date of De		000	3. Time of Dea
Physici Medi/	_	Kaı	ren A. Klo	oosterman							Month August	Day 27.	2005	10:30 A
Examir		4a. Facility Name	(If not institution, giv	ve street and numbe	ər)		4b. City.	, Town, or	Location o	of Death			ounty of Death	
		Genesia	s Elderca	re					cna Pa			Ar	nne Aru	
uneral irector		5. Social Security 213–66–0 Usual Residence	0319	Sex 1□M 2⊠F	Age (In yrs.	last birthday) Yrs.	If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Da 8–26–	ay, Year)		place (State or Fo intry) Jersey
M H		10a. State	10b. County		10c. Cí	ty, Town or Lo	ocation							10d. Inside City Li
r 28a-f ehow	ō	Maryland	Baltimo	ore	7	l'owson								1 ☐ Yes 2 💆
or 28a	Irec	10e. Street and N	umber				10f. Zi	p Code				10g. Citizer	n of What Cou	intry?
eme 23a or	a D	740 Camb	cerley Cir	rcle				212	204			US	SA	
iteme in	Funeral Director	11. Marital Status		12. Was Decede Armed Force	nt Ever in U	J.S. 13.	Was Dece	dent of Hi	ispanic Dri	gin? (Spe	ecfy Yes or N Rican, etc.)	0- 14.	Race - Amen Black, White	
o di			rried 2 Married	1 ☐ Yes 2 0					Specify:				oecify:	, etc.
natural',	d by	3 Widowed	4 Divorced	Year or Date	s:								WD	
	Be Completed	(Sp	15. Decedent's E ecity only highest gr			16a. Dece (Give life.	dent's Usu kind of wo	al Occupa ork done d	ation <i>during</i> mosi	t of work	ing	16b. Kind	of Business/In	ndustry
th as	E G	Elementary/Sec	condary (0-12)	College (1-40	or 5+)			130 1011100	"/				Modda	.1
d other then event, the Ma	ပိ	17. Father's Name	e (First, Middle, Last			INU	ırse_		18. Mothe	er's Name	(First, Middle	e, Maiden Su	Medica	<u>1</u>
0 .	To B	Jo	ohn E. Klo	oosterman						Fra	nces L.	Bala	zik	
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E 4		20a. Method of D			20b.	Place of Disp	osition (Na	me of	iding	COV	Date ADDS	20c. Locat	MD 21 tion - City or T	own, State
		1 Burial	2 ☐ Cremation 3 [5 ☐ Other (Speci	☐Removal from Sta		_{cemetery, cre} kemont			1	9-2-				lle, MD
Important: f any injury o once.		A	Funeral Septice_Lice		La									cal Home
Impo eny i		1/s/c	11/1/1/11	1										10 21037
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aminer I-transit	al Examiner	disease or condi-	conditions, financiate derlying or injury	a. Complia Due to (or b. Due to (or c.		ns of quence of):								
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		For State Registrar 1. Decedent's Name (First, Middle, Last)	State of Maryland			of Death		Re	g. No.	005	
Physici /Medic Examin	cal	Miriam Kramer 4a. Facility Name (If not institution, give s	treet and number)		4b. City, To	wn, or Location of	Αι	Date of Death Month ugust	21,	Year 2005 ounty of Deat	3. Time of Death 7:15P
uneral rector		Manor Care − P 5. Social Security Number 057-07-7423 6. Sex		st birthday) Yrs.	Poto If Under 1 Y Months D		24 Hrs. 8 Min. M	Date of Birth (Month, Day,		ntgome 9. Birt Co New	nplace (State or Foreig uotry) York
Important: If Item 27 is marked other than "natural", or itama 23s or 28s-f show any injury or other traumatic event, the Madical Examinar must be rightlished at 200s.	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Montgome 10e. Street and Number		Town or Lo	cation	vda		10	O Citizo	n of What Co	10d. Inside City Limit:
a 23a or	Funeral Director	10316 Holly Hill I			208	354			U. S	S. A.	
ral', or itam Examiner n	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Deceden f Yes, specify 1 ☐ Yes 2 ②	t of Hispanic Ori Cuban, Mexican No Specify:		fy Yes or No- can, etc.)		. Race - Ame Black, White pecify: W	
than "natur the Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12 Years	cation completed) College (1-4or 5+)	life. l	DO NOT use i	ione durina mos	it of working			of Business/	Industry
arked other atic event, i	To Be Co	17. Father's Name (First, Middle, Last) (Unknown)	Weiss			18. Mothe	er's Name (i Lara	First, Middle, N	laiden Su		
27 is ma er trauma		19a. Informant's Name/Relationship (Ty. Ian M. Kramer - So				treet and Number					
ant: If Item		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ R 1 4 □ Donation 5 □ Other (Specify)	cen	ce of Dispo netery, cren nt Lel	sition (Name natory or othe Danon	rolacel	Dat 3/24/2			tion - City or hi, Ma	Town, State aryland
any Inj 2002		21. Signature of Funeral Service License	Otottemen	E E 0	Name and A	Address of Facility Fundament	eral	Ritest	fon;	Inc.	and 20852
sician edical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Clostridi	Do not ent	er the mode o	f dying, such as	cardiac or r				Approximate Interval Between Opset and Death MONTH
hysiclen and the burial-transit	Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CHOSCITUTION DIFFICUTION ON A consequence of): Osteoporosis Due to (or as a consequence of): CHOSCITUTION DIFFICUTION OF THE COLUMN OF TH									
attending p for use as	Physician/Medical	in the past 12 months? 1 Yes 24 No	3c. If yes, outcome of pregnand 1 Live birth 2 Fetal d 4 Pregnant at time of dea	leath 3	Ectopic pregi				236	d. Date of deli	ivery Day Year
been signed by the should be detached	þ	9 Unknown Part II. Other significant conditions con	ntributing to death but not result	ing in the u	nderlying caus	se given in Part I.					the cause of death?
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is certificate director, pag	on: To Be	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be		R/Outpatier 28b. Time of Injury	28c	Other: 4 Nu Nu Injury at Work?	28 No	Check only one 5 Reside d. Describe ho f. Location (Str City or Town	nce 6 [w injury o	occurred	cify) oral Route Number,
무교	E	4 Homicide									
무교	dical Certificati	29a. Certifier X Certifying Phy (Check only 2 Medical Exami	sicien: To the best of my knowner: On the basis of examination	ledge, deat	h occurred at i	the time, date an my opinion, dea	nd place, an	d due to the ca at the time, da	use(s) ar	nd manner as lace, and due	stated. to the cause(s)
After th funeral	Medical Certif	29a. Certifier X Certifying Phy	sicien: To the best of my knowner: On the basis of examination and manner stated.	ledge, deat on and/or in	vestigation, in	the time, date an my opinion, dea icense number	nd place, an	at the time, da	ete and pl	nd manner as lace, and due signed (Month	to the cause(s)

				-	rtment of Health and Natificate of Death		ene	5 20050
	- · · · ·		Decedent's Name (First, Middle, Last)			2. Date of Death	- 1 0 0	3. Time of Death
	Physicia /Medio		BARRY NEIL	KI	RKWOOD	AUGUST	27 200	5 600 PM
	Examin	er	4a. Facility Name (If not institution, give street and number) 4043 Hunt Crest Road		4b. City, Town, or Location of Death Jarrettsvill		4c. County of D	rford
-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bir	thday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9.	Birthplace (State or Foreign Country)
	Director		210	Yrs.	Months Days Hours Min.	11/19/	1949	Maryland
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Lo	cation			10d. Inside City Limits
	Maryi -1 sho	tō	MD. Harford		Jarretts	ville		1 ☐ Yes 2 No
	th the	irec	10e. Street and Number		10f. Zip Code		g. Citizen of Wha	t Country?
	ath wi	raic	4043 Hunt Crest Road		21084		United	States
	after death with the Maryland or Items 23a or 28a-f show its of runs be redfilled at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Never Married 2 Married 1 Yes 2 ★ No	13. V	Vas Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - A Black, V	American Indian, Vhite, etc.
0000	urs aft	by F	1 Never Married 2 Married 1	1	☐ Yes 2 No Specify:		Specify:	White
ה ה	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or flems 23a or 28a-1 show event, the Medical Exameter man be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	Deced	ent's Usual Occupation	king 16	Sb. Kind of Busine	
7	filed within Hygiene. wher than "	mpi	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done during most of work OO NOT use retired)		Harf	ord County
2	e filed within al Hygiene. other than ' vent, I'le we	e Co	13 0 0	hı	ef Custodian	e (First, Middle, Ma		f Education
iand	should be nd Mental markad c	To B	William Russell Kirkwoo	od.	Luell			Kenlv
ary	should and Men is marka				g Address (Street and Number or Ru			
2 (b	is 1 and 2 should of Health and Men item 27 is marka other traumatic		Robert L. Kirkwood/Brother 20a. Method of Disposition 20b. Place of		6 Mill Street			Pa. 17321
	Pages nent of H		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	ry, cren	natory or other place)		oc. Location - City	
бантто	그 돈 뿐 글		*4 □Donation 5 □Other (Specify) Bethe 21. Signard of Funeral Service Licensed		Cemetery 8/30 Name and Address of Facility	/2005 M	adonna	Maryland
Ď	permi Depar Impoi any ir		1. Gladelen Kurk	-	E.G. Kurtz & S	on Fune	ral Ho	Maryland me. P.A.
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not ente	er the mode of dying, such as cardiac	or respiratory arres	it,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		ic Caroliova	soular	diges	Onset and Death
	Examiner		Due to (or as a consequence	of):				
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	of):				
	be executed iclan and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence)	of).				
8/60,	ficate be executed physician and is the burial-transit	aiE	Sub-to-(of as a consequence	oi).				
200	tificate ig physi as the l	ledicai	d					
Š	death certific e attending p id for use as l	an/N	IF FEMALE: 23b. Was decedent pregnant in the post 1/2 months? 23c. If yes, outcome of pregnancy 1	3□	Ectopic pregnancy		23d. Date of	
	0 0	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 9 □ Unknown	5□	Other (specify)		Month	Day Year
ŗ.	law requires that the de as been signed by the a 2 should be detached f		Part II. Dther significant conditions contributing to death but not resulting in	n the ur	derlying cause given in Part I.	23e. Did toba	cco use contribut	te to the cause of death?
cords	quires an sign uld be	ed by	He per tension			1 ☐ Yes	2 XNo 3	Probably 4 Unknown
ဝ၁	law requit as been s 2 should	Completed				24a. Was an	24b. Were	e autopsy findings available to completion of cause of
T	The l	Com				autopsy performe	deati	h?
Vital	ysician: The lavis certificate has director, page 2	Be	25. Was case referred to medical examiner? Hospital:		Othor	th (Check only one)		
0	ding Phys th. After this funeral dir	To :t	27. Manner of Death 28a. Date of Injury 28b. 1	Time of	3 DOA 4 Nursing H	ome 5 Resident 28d. Describe how	ce 6 Other (5	Specify)
0	Attending death. ctor: Afte y the fune	atior	1 Natural 5 Pending (Month, Day Year) I	njury	28c. Injury at Work? M 1 Tyes 2 No		,,	
Division	or Attending Physician: Ifter death. Director: After this certific in by the funeral director.	ertification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	ırm, stre	eet, factory, office	28f. Location (Stre City or Town,		r Rural Route Number,
2	pital o	O	29a. Certifier 1 Certifying Physician: To the best of my knowledge	4 1				
	e Hos 24 hc e Fun letely	edical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge (Check only one) Medical Examiner: On the basis of examination an and manner stated.	e, death id/or inv	estigation, in my opinion, death occur	and due to the cau red at the time, date	se(s) and manne e and place, and	r as stated. due to the cause(s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Me	29b. Signature and title of certified		29c. License number	290	1. Date signed (M	onth, Day, Year)
	10	1,0	Brad A Gullen MA, DIME		10014206	a	weest	28,2005
	12	11	30. Name and address of p son no completed cause of death (Item 23a). PERMANAT WANN MODINE 31. Date filed (Month Day Year).	Type, I	HOLADIRA AL	K Palix	& WA	28,2205
	Sta	te	31. Date filed (Month, Day, Year) 32. Re strar's Signature		Marian IV	- DIVE	o my	XXXX
	Registr	21	#Ula 3 (1-2004 Manager //	(2)	Track a			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 28°, 2005° AUGUST 2035 SHIRLEY LARSON Η. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner UNIVERSITY HOSPITAL BALTIMORE CITY BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)

7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🂢 F 49 Yrs Director 222-42-9653 SEPT. 4, 1955 GERMANY Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f ahow 1 ☐ Yes 2√ No DELAWARE NEW CASTLE NEW CASTLE Direct 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ral', or itema 23a or Exercicer must be 34 SCOTTIE LANE 19720 UNITED STATES OF AMERICA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify: WHITE δ 3 ☐ Widowed 4XX Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 CONTROLLER CHEMICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental 27 is marked or treumatic eve Peges 1 and 2 should be JOHN THOMAS DOBROWOLSKI ELFRIEDE M. SCHUBERTH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if itam 27 i JAMIE J. LARSON / SON 8 JAY DRIVE, NEW CASTLE, DE 19720 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) permit. Pege Department of important: if any injury or once. MAYERDALE CREMATORY SEPT.3,2005 NEWARK, DE 21. Signature of Fun I Se SPICER-MULLIKIN FUNERAL HOMES, INC. 1000 N. DUPONT PKWY., NEW CASTLE, DE Part: Enter the disease, or complications shock, or heart failure. List only one cause Approximate Interval Between Onset and Death used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence or, Attanding Physician: The law requires thet the death certificate be executed resulting in death) Last Due to (or as a consequence of): by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy signed by the atte Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown this cartificate has been s at director, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? Yes 2 No 2 🗆 No 25. Was case referred to medical examiner?

1X Yes 2 □ No Be 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient 2 📉 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To Diractor: After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Instorcyclist in accide 1 Natural 5 Pending 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) XX No death. Accident investigation 1 🗌 Yes 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide ö To the Hospital o within 24 hours aft To the Funeral Di Con 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2XX Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME AUGUST 29, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 PENN STREET, BALTIMORE, MARYLAND, 21201 2005 32. Revistrar's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Phy. Gea?)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	Dooddon o ran	me (First, Middle,	•	u ah			2. Date of Death Month	_	3. Time of Death			
ical	da Facility Name		Irving LaBru	usn	45 O'5. T			er 04, 200				
iner		negate Di			Freder	or Location of Death		4c. County of Dea				
	5. Social Security		. Sex 7. Age	e (In yrs. last birtl	nday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth					
r	213-78-0	989	15xM 2□F	43 Y	rs. Months Days	Hours Min.	June 16,	1962 Mar	rthplace (State or Forei Country) Vland			
	Usual Residence	1		10. Dit. T.								
7	10a. State	10b. County		10c. City, Town					10d. Inside City Limit			
ecte	Maryland 10e. Street and N		ıck	Freder	10f. Zip Code		100	- Civina of Miles O	X			
ā	123 Sto	negate D:	rive		2170	17	10	g. Citizen of What C U.S.A.	•			
Funeral Directo	11. Marital Status		12. Was Decedent I	Ever in U.S.	13. Was Decedent of H		pecify Yes or No-	14. Race - Am				
고		rried 2 Marrie	Armed Forces?	No			Rican, etc.)	Black, Whi	ite, etc.			
d by	3 Widowed	4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify: W	hite			
Completed	(Spe	15. Decedent's acify only highest			Decedent's Usual Occup (Give kind of work done	during most of work	king	6b. Kind of Business	s/Industry			
ם	Elementary/Sec	condary (0-12)	College (1-4or 5	5+)	life. DO NOT use retire	d)		G 1	61			
ပိ	17. Father's Name	e (First, Middle, La	nst)		Foreman	18 Mother's Nam	ne (First, Middle, M.	Cabinet	Snop			
Be	A1C 1 1	H. LaBrus	*				1. Danner	alderi Sumame)				
오		Name/Relationship	o (Type, Print)	19b.	Mailing Address (Street			City or Town, State.	Zip Code)			
	Bonnie M	. Messicl	(Mother		441 Cannon							
	20a. Method of Di		_	20b. Place of	Disposition (Name of crematory or other pla	cal	Date 2	0c. Location - City or	r Town, State			
To Be Completed by Funeral Director		2 ☑ Cremation / 3 5 ☐ Other (Spe	□ Removal from State scify)		burg Cremat		2005 S ₁	mithsburg	, Maryland			
	21. Signature of	Funeral Service Lie	censee		ROBERT E.	SS OF FACILITY &	100					
i .) (K.	ut E.	A H	T	1201 NORTH	MARKET S	ST., FRED	ERICK. MD	21701			
	23a. Part . Enter shock, or he	r the disease, or co eart failure. List or	ometic thousand t caused by one cause on each lin	the death. Do no	ot enter the mode of dyin	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between			
	disease or condit	ion	Cardiome	23a. Part. Enter the disease, or commissions to caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Cardiomegaly								
	resulting in death	1)				Onset and Death						
			Due to (or as	a consequence o	f):				Onset and Death			
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Registrar DHMH 17 Rev 1/2001

			For State Registrar	State of N	Maryland		artment of H			iene ,	2005	29	962
			Decedent's Name (First, Middle,	Last)					2. Date of Deat	th	V	3. Time o	of Death
	Physici /Medi		BLAIR LE	WIS _					Month AUGUST	26,	Yeer 2005	1:30	РМ
	Examir		4a. Facility Name (If not institution,	give street and number	r)		4b. City, Town, or	Location of Death		4c. C	ounty of Death		
			HOLY CROSS HOSP					SPRING			4ONTGOM		
	Funeral Director		5. Social Security Number 577-44-1589 Usual Residence of Decedent		Age (In yrs. Ia 73	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, FEB • 15	, Year)	9. Birthi Coul 32 WASH	olace (State ntry) INGTON	or Foreign
	land ow		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside (City Limits
	Mary Frah	to	MARYLAND MONTG	OMERY	ROC	KVILLI	Ε					1 X Yes	2 □ No
	h the	Director	10e. Street and Number				10f. Zip Code		1	0g. Citize	on of What Cou	ntry?	
	th wit	aic	4810 CREEK SHORE	DRIVE			20852			U.S.	.A.		
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. It was 13 a or 28e-1 ahow tiam 27 is marked other than "natural", or Itams 23a or 28e-1 ahow other traumatic event, it a Medical Exporter menter toolified at	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deceder Armed Forces d 1 XYes 2 If Yes, Give Year or Dates	s?] No		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 XNo	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)		Race - Ameri Black, White, pecify: WHI	etc.	
2-0	72 ho natur	eted	15. Decedent's (Specify only highest			16a. Deced	tent's Usual Occupa	ation	cina	16b. Kind	of Business/In	dustry	
21	within 7 ene. than "r	Completed by	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life. I	AL INTELL)		U.S.	GOVERN	MENT	
121	filed w Hygier othar tl	S	12 17. Father's Name (First, Middle, L.	nael .				18. Mother's Nam					
anc	d be finital himself ced of	Be c	NATHAN	LEWIS				REBE		Maidell St	HURWIT	Z	
Maryland	id 2 should be Ith and Mental 27 is marked 27 is marked 17 is marked	P	19a. Informant's Name/Relationshi				ng Address <i>(Street a</i>					-,	
Baltimore,	Pages 1 and 2 ent of Health nt: If itam 27 i		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Spi		1 00	nce of Dispo metery cred ENS	sition (Name of matory or other place D MEMORTA	(4)			ation - City or To		
Balti	permit. Pages 1 Department of I Important: If its any injury or ot		21. Signature of Funeral Service Li	•		ED\	Name and Addres					5.0	
			23a. Part 1. Enter the disease, or o shock, or heart failure. List o	omplications that caus	ed the death.		9.1 ROCKVI er the mode of dyin				FID ZUO	Approxima Interval Be	
	Physician		Immediate Cause (Final disease or condition	SEPSI							1	Onset and	
	/Medical		resulting in death)	a Due to (or a	is a conseque	ence of):				•			and warene
	Examiner		Sequentially list conditions,	b									
	Sit 9d	inel	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a conseque	ence of):							
	cate be executed physician and the burial-transit	dicai Examiner	that initiated events resulting in death) Last	c Due to (or a	ıs a conseque	ence of):							
8760,	be ed	aiE			,								
687				d									
.O. Box	that the death certifi ed by the attending detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unkno <i>wn</i>	2 ☐ Fetal o	death 3	Ectopic pregnancy Other (specify)			23	d. Date of deliv Month	ery Day	Year
Ω.	res that the igned by th be detache	y Ph	Part II. Other significant condition	s contributing to death	but not resul	ting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use	e contribute to t	the cause of	death?
rds,	requires been sign hould be								1 □ Y	es 2 🔀	No 3 Pro	bably 4]Unknown
Record	e law has b je 2 s	Completed			24a. Was autc perf						24b. Were auto prior to co death? 1 \(\sum \text{Yes}	impletion of	available cause of
Vital	ician: Th certificate ector, pag	O	25. Was case referred to medical					26. Place of Dea	1 ☐ Yes :	2 (24No) ne)		20110	
_t <	S S	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 XInpa	tient 2 E	R/Outpatien	t 3 DOA	er: 4 🗌 Nursing H	ome 5 🗆 Reside	ence 6	□Other (Speci	<i>fy)</i>	
n of	ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of In (Month, D	jury Day Year)	28b. Time of Injury	28c. Injun World	at c?	28d. Describe ho	ow injury	occurred		
sio	Attending r death. actor: After by the fune	cati	2 Accident investiga 3 Suicide 6 Could no				M 1□	Yes 2 □No					
Division	l or Atten after deatl Diractor: I in by the	Certification:	4 Homicide determin	ad 28e. Place of I	njury - At hon etc. <i>(Specify)</i>	ne, farm, str	eet, factory, office		28f. Location (Si City or Town		Number or Rur	al Route Nui	nber,
	To the Hospital or Attenwithin 24 hours after deatl To the Funaral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) Certifying 2 Medical E	Physician: To the bes kaminer: On the basis and manner:	of examination	rledge, death on and/or inv	n occurred at the time vestigation, in my of	ne, date and place pinion, death occu	, and due to the c rred at the time, d	ause(s) a late and p	nd manner as s lace, and due t	stated. to the cause	(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier				29c. License	number	2	9d. Date	signed (Month,	Day, Year)	
}	1		· Celle	MD			DOC	61390		AUGU	ST 26,	2005	
	7		30. Name and address of person w	ho completed cause of	REST G	LEN R	Print) OAD, SILV		G, MD 20	910			
	Sta Registr	_	31. Date filed (Month, Day, Year)	2005 32. Figis	strar's Signatu	7. A	rester						
		- ;	Hud 9 0	1								-	

			1 - For State Registrar	State of Maryla	-	artment of F			ene	0.00
	Physici /Media	al	1. Decedent's Name (First, Middle, Last) Warren G		inn_			2. Date of Death Month SEPTEMBE	Day Ye	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
	Examir Funeral	er	4a. Facility Name (If not institution, give statement of the MEMORIAL HOSPITAL 5. Social Security Number 6. Sex		:. /ast birthday)	4b. City, Town, or CUMBERI If Under 1 Year		8. Date of Birth	4c. County of t	
	Director			M 2□F 82	Yrs.	Months Days	Hours Min.	Mar 28,	1923	Country) MD
	e Marylan 8a-f show Hiffed at	ctor	MD 10a. State 10b. County Allegan	1	Cuml	perland				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with th	Funeral Director	714 Lafayette Aver	ue		10f. Zip Code	21502	100	g. Citizen of Wha	•
900	ours after des rel', or Items Examinative	by	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12, Was Decedent Ever in t Armed Forces? 1 ☑ Yes 2 ☑ No If Nes, Give Year or Dates: WW		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, V	American Indian, White, etc. Vhite
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23e or 28a-f show entry injury or other treumatic event, the Medical Example at modified at once.	Completed	15. Decedent's Edu- (Specify only highest grade Elementary/Secondary (0-12) 12	cation completed) College (1-4or 5+)	(Give	DO NOT use retired	during most of work	ing	Sb. Kind of Busin	
/land	should be file ind Mental Hy s marked oth umatic event	To Be (17. Father's Name <i>(First, Middl</i> e, <i>Last)</i> , William Linn					et Reckley		
	and 2 sho ealth and I n 27 is me		19a. Informant's Name/Relationship (Type Marion Linn	ов, Print) wife		ng Address <i>(Street a</i> Lafayette		a <i>l Route Number, C</i> Cumbe		te, <i>Zip Code)</i> MD 21502
Baltimore,	Pages 1 and the ment of He and: If item ury or other		20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Place of Dispo cemetery, cren Tabor C	sition (Name of natory or other plac emetery	e)		Spring G	
Balt	permit. Departr Importe eny injt		21. Signatur of Funeral Service Licens	ALLIN	. 22		i Funeral Ho	ome, PA :: Cumberla	nd MD 21	502
	Enysician		23a. Part. Enter the disease, or combli- encek, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the deale cause on each line. END STAGE C		er the mode of dyin	g, such as cardiac	or respiratory arres	l,	Approximate Interval Between Onset and Death 5 YEARS
	/Medical Examiner		resulting in death)	Due to (or as a conse		OBSTRUCT	IVI LUNG	DISEASE		J IEARS
8760, 中	cate be executed ohysician and the burial-transit	dical Examiner	is any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	Due to (or as a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (o						
.O. Box 68	The law requires that the death certificat te has been signed by the attending phy page 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ac. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 6 9 □ Unknown	aldeath 3 □	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
٥.	w requires that been signed by should be deta	by	Part II. Other significant conditions con	tributing to death but not re	sulting in the ur	nderlying cause give	en in Part I.		4/	e to the cause of death? Probably 4 Unknown
Il Records,		Completed						24a. Was an autopsy performe	d2 death	e autopsy findings available to completion of cause of 1? Yes 2 \sum No
Division of Vital	nding Physicien: Th uth: :: After this certificate e funeral director, pag	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No H 27. Manner of Death 1 Natural 5 Pending envestigation	ospital: 1 Inpatient 2 C 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work	er: 4 ☐ Nursing Ho	n (Check only one) me 5 ☐ Residenc 28d. Describe how		Specify)
Divis	ospitel or Attending I hours after death. unerel Director: After ily filled in by the funer	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, stre	eet, factory, office		28f. Location (Stree City or Town, S	et and Number of State)	Rural Route Number,
	F 22 F 35	edical C	29a. Certifier (Check only one) 1 Certifying Phys	icien: To the best of my known: er: On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at the time restigation, in my op	ne, date and place, pinion, death occurr	and due to the caused at the time, date	se(s) and manner and place, and	r as stated. due to the cause(s)
	To the within 2 To the complet	W	29b. Signature and title of certifier	Chotani		29c. License			Date signed (M	
	3	•	30. Name and address of person who cou			Print)	-		.502	9, 2005
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	المنظير		<u>.</u>		

			1 - For State Registrar	St	ate of N	Maryland / D	epartm Certific	ent of F ate of	lealth a Death	ind M	lental	Hygie Reg	ene 2 (005	29961
			1. Decedent's Name (First, Midd	lle, Last)		-					2. Date o	f Death			3. Time of Death
	Physici		Gilda Mary	Loblev							au qu		Day 3つ 20	Yeer S	1:30 PM
	/Medio Examir		4a. Facility Name (If not institution	on, give street	and numbe	ər)	4b. (City, Town, or	r Location of		74	3.1	4c. County		7.70
			Washington	County	Hosp	ital		Hage	erstow	vin .			Machi	naton	County
	Funeral		5. Social Security Number	6. Sex	7	Age (In yrs. last birth		nder 1 Year	If Under 2	4 Hrs.	8. Date o	f Birth			lace (State or Foreign try)
	Director		160-40-2621	1 □ M	2 X F	57 Y	rs. Mon	ths Days	Hours	Min.	Jan	, <i>Day</i> , Y	1948	Pen	nsylvania
	D .		Usual Residence of Decedent												7
	how		10a. State 10b. Count	4		10c. City, Town	or Location							10	0d. Inside City Limits
	Ma P-f	cto	Maryland Was	hingto	n	На	agerst	OWD							Yes 2 No
	th th	Director	10e. Street and Number					. Zip Code				100	. Citizen of	What Coun	try?
	th wi		13044 Hawkins	Drive				2174	42				U.S.	Δ	
	dea	Funeral	11. Marital Status	12. W	as Deceder	nt Ever in U.S.	13. Was D	ecedent of H specify Cuba	ispanic Orig	in? (Spe	ecify Yes o	r No-	14. Rad	e - America	
21215-0036	172 hours after death with the Maryland "neturel", or Items 23e or 28e-f ehow policel Evertifier must be notified at	þ	1 ☐ Never Married 2X Ma 3 ☐ Widowed 4 ☐ Divorce	rried 1	☐ Yes 2 Yes, Give	XĮ No		s 2X No	Specify:	Fuelto	nicari, etc.	.)		ck, White, e y: Whi	
9	72 ho	Completed		nt's Education				Usual Occup		-6 4.7		16	b. Kind of B	usiness/Ind	lustry
2	S - 2	pie	(Specify only higher Elementary/Secondary (0-12)		ollege (1-40		life. DO NO	f work done o OT use retired	ouring most ()	or worki	ng				
21		Con			4		minis	tration	ze Ass	ista	ant	ĸ	itche	1 Cah	inet Mfg.
ğ	be filed ital Hygi od other event, L	Be (17. Father's Name (First, Middle	, Last)	-							ddle, Ma	iden Suman	ne)	Hick Hay.
<u>a</u>	should be not Mental marked o	To	Orlando Raffa	ele					Ci	142	Mart	~11i			
Maryland	S D E E		19a. Informant's Name/Relation	ship (Type, P	rint)	19b.	Mailing Add	ress (Street						State, Zip	Code)
	and 2 ealth a n 27 le		James David L	oblev	(Husba	and) 13	3044 F	lawkins	Circ	lo I	lagon	etow	m Mars	Freely	217/2
Ē,	of Heali item 2 other		20a. Method of Disposition	_	,	20b. Place of I	Jisposition .	(Name of or other place		D	ate	20	c. Location	City or To	wn, State
9	Pages nent of I		1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (al from Sta	Rest Ha			1	'ant	2 20	0.5	Harrow	~	Managara
Baltimore,	# E E E	- 1	21. Signature of Funeral Service		_	nest ne	1	e and Addres							Maryland
ã	permi Depa Impo eny ir		NDuna 1	2. 1	4,	10.1				DOL	ıgıas	Α.	Fiery	Funei	cal Home Land 21742
	Physician /Medical Examiner		23a. Part1. Enter the disease, o shock, or heart tarture. Lis Immediate Cause (Final disease or condition resulting in death)	t only one cal	use on each	ed he death. Do not line.	Can C	mode of dyin	g, such as c	ardiac o	r respirato	ry arrest			Approximate Interval Between Onset and Death
		Je.	Sequentially list conditions, if any, leading to immediate	J b. —	Due to (or a	as a consequence of):								
	icate be executed physician and s the burial-transit	Examin	cause. Enter Underlying Cause (Cisease or injury that initiated events	•											
oʻ	cate be execul physician and the burial-tran	EX	resulting in death) Last		Due to (or a	as a consequence of):								
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~	- "	Q)		1											
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	that sed b		Part II. Other significant conditi	ons contribut	ing to death	but not resulting in t	he underlyii	ng cause give	n in Part I.		23e. C	oid tobac	co use cont	ribute to the	cause of death?
Vital Records,	w requires been sign should be	ted by									1	ØYes	2 🗆 No	3 Proba	ıbiy 4 □Unknown
ecc	e taw r has be ge 2 sh	Completed									a	Vas an utopsy		Nere autop	sy findings available ipletion of cause of
Œ	Page T	Co									1 Ye	erformée s 2.∠	d?(death? I□Yes 2	
ita	ysicien: Th is certificate director, pag	Be	25. Was case referred to medica examiner?	al					26. Place o	of Death	(Check or	nly one)			
	ys di S	2	1 ☐ Yes 2 ☑ No	Hospit	al: 1 ☑ Impa	tient 2 ER/Outp	atient 3	DOA Othe	er: 4 🗆 Nurs	sing Hon	ne 5 🗆 F	lesidenc	e 6 Oth	er (Specify)	
J Of	ng Ph ter th		27. Manner of Death 1 ☑ Natural 5 ☐ Pendi	28	a. Date of In (Month, D	jury 28b. Tir	ne of ury	28c. Injury Work	at				injury occurr		
<u>ō</u>	ath. rr: Af	atic	2 Accident invest	igation			М		res 2□No	0					
Division	er de recto	titie	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deterr		e. Place of I	njury - At home, farn etc. (Specify)	n, street, fac	ctory, office		2		n (Stree		er or Rural	Route Number,
Ö	s afte	Certification;			Daniang,	oto. (opoony)					Ony or	7000, 0	naio)		
	To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer.	edicai (29a. Certifier 1 Certifyi (Check only one)	Exeminer: (To the bes	st of my knowledge, of examination and/	death occur or investiga	red at the tim tion, in my op	e, date and inion, death	place, a	ind due to ed at the tir	the caus	e(s) and ma and place, a	nner as sta and due to t	ited. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certific				T	29c. License	number	_		29d.	Date signed	Month. D	lay, Year)
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		-	30. Name and address of person	han armain	ad agrees =	doub /ba= 02-1 ~		v						-	
4-	15	-		A CCO				ical	1		11	11	. 1	• • •	00.00
	Sta	i o	31. Date filed (Month, Day, Year			1/1/0	18401	(CC)	camo	2 1	w.	102	Sear	an	mo
	Registr	_		1 2005		en B.	Some	1							

	1 - State of Maryland / Depart Certification	ment of Health and Mer ficate of Death	ntal Hygiene 2005	29965				
Physician /Medical	1. Decedent's Name (First, Middle, Last) Martha B. Long		Date of Death Month Day Year Aug 27 2005	3. Time of Death 6:00 AMM				
Examiner	4a. Facility Name (If not institution, give street and number) Genesis HealthCare - The Pines	b. City, Town, or Location of Death Easton	4c. County of Dea					
Funeral Director		lonths Days Hours Min.	Date of Birth (Month, Day, Year) 9. Bir (Month, Day, Year) C	thplece (State or Foreign ountry) cyland				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avant, it is Modeal Exercities must be notified at the contract of the Completed by Funeral Director	10a. State 10b. County 10c. City, Town or Locate Maryland Caroline Denton 10e. Street and Number 26270 Hobbs Road	ion 10f. Zip Code 21629 s Decedent of Hispanic Origin? (Specify Sec. specify Cuban, Mexican, Puerto Rici	10g. Citizen of What C USA Yes or No- 14. Race - Am					
ed within 72 hours after of within 72 hours after of sygiene. I, It a Medical Exertiration of the Completed by Fun	1 Never Married 2 Married 1 Merca 2 No If Yes, Give 1 Secretary 15 Decedent's Education 16a. Decedent	as, specify Cuban, Mexican, Puerto Rici Yes 2 No Specify: It's Usual Occupation of of work done during most of working NOT use retired)	an, etc.) Black, Whi Specify: Blact 16b. Kind of Business Easton	ick				
vuld be filed with Mental Hygiene arked other tha atic avant, the TO Be Com		eon Tech. 18. Mother's Name (F.	Memoria irst, Middle, Maiden Sumame)	al Hospital				
d 2 should the and Me 17 is mark traumati	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing A	Address (Street and Number or Rural Re Hobbs Road, Dento	oute Number, City or Town, State,					
ages 1 an int of Heal	20a. Method of Disposition 1 Burial Cremation 3 Removal from State 20b. Place of Disposition cemetery, cremation	on (Name of Date ory or other place)	20c. Location - City or	Town, State				
permit. Pages Department of Important: If it any injury or or	21. Signature of Funeral Service Licensee 22. N	Mem. Park 08-31- ame and Address of Facility Bennie Smith Funer 26 Dover Street, E	al Home	No-Jelovac N				
Physician	23a. Part. Enerthe dise the complication that caused the death. Do not enter to shock, or hear failure. List only one on each line. Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death				
polyological physician and sthe burial-transit sthe burial-transit selfical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	al fatture						
The Cours, F.C. Box of the law requires that the death certific tale has been signed by the attending plage 2 should be detached for use as completed by Physician/Mec		topic pregnancy ther (specify)	23d. Date of de Month	livery Day Year				
w requires that the second signed by should be detailed by Philipped b	Part II. Other significant conditions contributing to death but not resulting in the under the conditions of the conditi	rtying cause given in Part I.	23e. Did tobacco use contribute t					
2			autopsy prior to death? 1 ☐ Yes 2 No 1 ☐ Yes	utopsy findings available completion of cause of s 2 \(\) No				
n OI ng Phys After this nneral di	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 27. Mannor of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	heck only one) 5 ☐ Residence 6 ☐ Other (Spe Describe how injury occurred	☐ Residence 6 ☐ Other (Specify)					
DIVISION of tall or Attanding P is after death. al Director: After ted in by the funer?	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	, factory, office 28f.	Location (Street and Number or R City or Town, State)	ural Route Number,				
DIVISION To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune Medical Certification								
To th Withir To th comp	29b. Signature and title of certifier	29c. License number 72593	29d. Date signed (Mon 8 · 2	th, Day, Year) 9-05				
(4)	30. Name and address of person who completed cause of death (Item 23a) (Type, Printing CHALL CROWLLY, MIS GIO DUT	CHMAN'S LANE	EASTON M.	0 21601				
State Registrar	31. Date filed (Month, Day, Year) 1 2005 32. Registrar's Signature		,					

		-	For State Registrar	State o	of Maryla		artment of H <i>rtificate of L</i>			giene 2 Reg. No.	2005	29966	1
		1. Decedent's Name (First, Middle, Last)						2. Date of De. Month	ath Day	Yeer	3. Time of Death	-	
	Physicia /Medic		Chloe Ann Lauer	c							2005	9:45 P M	_
	Examin		4a. Facility Name (If not institution	, give street and nu	mber)			Location of Deatl	h		ounty of Death		
徳,	10 A		5400 Vantage Po				Columbia	If Under 24 Hrs.	O Data of Bird		vard	alana (Ctata as Foreign	_
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 € F		rs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	(Month, Da	y, Year)		place (State or Foreign ntry)	
	Director		577 22 0863 Usual Residence of Decedent		98_				5/22/19	01/	Virg	Inia	
	/land	Ì	10a. State 10b. County		10c.	City, Town or L	ocation					10d. Inside City Limits	
	Man a-f-ah	ģ	MD Howard	Ē	C	olumbia						1 ☐ Yes 34 ☐ No	_
	in the	Director	10e. Street and Number				10f. Zip Code			10g. Citize	on of What Cou	ntry?	
	23a c		5400 Vantage Po				21044				JSA		_
	r dez	Funeral	11. Marital Status	Armed F		n U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puer	to Rican, etc.)	- 14	I. Race - Ameri Black, White,		
2	s effe	by Fi	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	ned 1 [] Yes If Yes, G Year or I	2 ∰No ive Dates:		1□Yes 2∏ No	Specify:		S	Specify:	White	
3	tural	ed	15. Deceden	t's Education		16a. Dece	dent's Usual Occup	ation	eta in a	16b. Kind	d of Business/In		-
IIIQ XIX 13-0030 be filed within 72 hours efter death with the Maryland lal Hygiene.	nir 7	Completed	(Specify only higher Elementary/Secondary (0-12)	1) (1-4or 5+)	life.	kind of work done of DO NOT use retired	during most of wo	rxing				
7	d with	E O	12			Admin	istration			***	of In	terior	_
2	ould be filed with Mental Hygiene. Brked other than stic event, the M	Be (17. Father's Name (First, Middle,						me (First, Middle,		umame)		C
	should to and Ment marked amatic e	2	Wayland Farrel						mma Hayr		T Ch. 1 7:	- 0-4-1	_
	2 sho		W. Douglas Slo		-T25.7		ing Address (Street						
ະ ນົ	1 and Health em 27		20a. Method of Disposition				osition (Name of imatory or other place		Date		ation - City or T		
5	Pages nent of P int: If ite		1 ☑ Burial 2 ☐ Cremation		1 State	_		'	/2005	Whoat	con, MD		
aitimo	그 등 원 경		*4 Donation 5 Dother (S 21. Signeture of Funeral Service		ψα		eaven Cem 2. Name and Addre				ily FH, Inc		
מ	Depa Impo any ii		Marshay Po	Ida Mo	1441		112 Old C						
			23a. Part1. Enter the disease, o shock, or heart failure. List	complications that	caused the d	leath. Do not er	iter the mode of dyin	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	5.10	of a	Shep	o Pen	al te	ilnot			Onset and Death	
	/Medical		resulting in death)	Due to	(or as a con	sequence of)							
	Examiner		Sequentially list conditions,	1 H	yse	oten	8000	_			_		_
	sit sit	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	o (o a a con	sequence of):	1.000	Local to Salina as			September 1		
	and and Il-tran	Examin	resulting in death) Last Due to (or as a consequence of):					1	TROUGH.				
2/60	The law requires that the death certificate be executed the sabeen signed by the attending physicien and tage 2 should be detached for use as the burial-transit			La pt	y Rea	eti co	den	ie					
200	ificate g phy: as the	edical			11								-
X Q Q	leath certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant		utcome of pre		□Ectopic pregnancy	v		23	3d. Date of deliv		
	death	icia	in the past 12 months? 1 □ Yes 2 ₺ No		gnant at time		Other (specify)	, 			Month	Day Year	
J Ö	res that the designed by the a	Phy	9 Unknown	-		and the state of the state of		ran in Dart I	23a Did	tobacco us	e contribute to	the cause of death?	C
Ś	ires th signed d be d	þ	Part II. Dther significant conditi	ons contributing to		سادي		los to		Yes 2			
5	w requir been si should	eted	ela Cos	1 10	Versi	CUIGN	ACCC	War f	24a. Was		24b Word aut	opsy findings available	
Hecords,	e law has t	Completed	Deme	nta					auto		prior to d	ompletion of cause of	
_	r: Th licate r. pag		65 1M					OC Plans of Da		2€ No	1 🗆 Yes	2 1 No	
Vital	siciar certii irecto	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ No	Hospital	Unnation	2 ER/Outpatie	ent 3 DOA Oth	205	eath <i>Check on</i> Home 5 Res		□Other (Spec	afv)	
ō	y Phy er this eral d	n; To	27. Manner of Death	28a. Dat	e of Injury onth, Day Yea				28d. Describe				
<u></u>	nding ath. r: Afte	atio	1 Natural 5 ☐ Pendi 2 ☐ Accident invest	ng (Mic igation	mui, Day 19a	ur) Injury		Yes 2 □ No					
Division of	r Atte	Certification;	3 Suicide 6 Could 4 Homicide deter	nined 200. Fld	ce of Injury ding, etc. (Sp	At home, farm, s	treet, factory, office			(Street and wn, State)	Number or Rui	ral Route Number,	
<u> </u>	itel or rel Di												_
	Hosp 14 hou Fune Fune	edical	(Check only 2 Medica	ng Physician: To to I Examiner: On the	basis of exam	knowledge, dea mination and/or	ith occurred at the ti nvestigation, in my	me, date and plac opinion, death occ	ce, and due to the curred at the time	cause(s) a , date and p	and manner as place, and due	stated. to the cause(s)	
	To the Hospitel or Attending Physician: The Is within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page 2	Med	one) 29b. Signature and title of certifi		paer stated.		29c. Licens	se number		29d. Date	signed (Month	, Dey, Year)	
1	ઠેનેદેન		113 6			> .	A A	- ニルクハ		Augus	st 29,	2005	
			30. Name and address of person	who completed ca	use of death	(Item 23a) (Type	p, Print)	V Tolon					-
			WillieBMV	EleBA 4	113 Ca	enma	wealt	2 AV	catons	lille,	MI	21228	_
		ate	31. Date filed (Month, Day, Yea, AUG 3	0 2005	Pagistrar's S	Signature	1			- /	_		
	Regist	rar	,,,,,,	O EUUJ	THERE.	15	CORNE !						

		į.	For State Registrar	State of Marylan	d / Depa <i>Cer</i>	irtment of H	lealth and M Death	lental Hygie	ene 2005	29967
			Decedent's Name (First, Middle, Last)					2. Date of Death Month		3. Time of Death
	Physicia /Medic		CAROLYN SUE M	ILLER					9, 2005	5:00 AM
	Examin		4a. Facility Name (If not institution, give str			4b. City, Town, or	Location of Death		4c. County of Death	
			11645 BACHELOR'S			SWANN			CHARLES	
	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In yrs. 66	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y SEPT - 29	9. Birthp Court 9,1938 WE	place (State or Foreign ntry)
	pu .		Usual Residence of Decedent 10a. State 10b. County	100 6	. Town and a					
	shov	٦	Toa. State	Toc. Cit	y, Town or Lo	cation			1	0d. Inside City Limits 1 ☐ Yes X☐XNo
	the N	Director	MARYLAND CHARLE 10e. Street and Number	S	SWANN	POINT				
	with a or :	ä				10f. Zip Code	_	100	g. Citizen of What Cour	itry?
	eath	era	11645 BACHELOR'S	HOPE CT. Was Decedent Ever in U	S 13 V	2064	5 ispanic Origin? (Spe	ocify Ves or No-	U . S . A .	ean Indian
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked othar then "natural", or iteme 23s or 28s-f show any injury or other treumatic event, the Medical Examiner must be notified at once.	by Funeral	1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give → Year or Dates:	ŀ	Yes, specify Cuba	Specify:	Rican, etc.)	Black, White, Specify:	
ğ	72 ho	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give			ent's Usual Occup	ation during most of worki		bb. Kind of Business/Industry	
2	thin is	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired	during most or workii ()	ng		
	filed wi Hygien Sthar th	S	12		HO	MEMAKER			OWN HOME	
pu	be fit d off	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Ma	aiden Sumame)	
<u>Y</u>	should nd Men marke umatic	ို	EUGENE R. ISNER,				WILMA	COONTZ		
Maryland	2 sh and is m		19a. Informant's Name/Relationship (Type		1				City or Town, State, Zip	
	1 and Health em 27 ther tr		LINDA MAYNARD-DA		1473	5 JENNI sition (Name of	FER CT.		MARYLAN	
or	Pages nent of Hent of Hent of Hent of Hent of Hent or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rer	noval from State	emetery, cren	natory or other place	(8)		c. Location - City or To	wn, State
altimore,	t. Partmer		`4 □Donation 5 □ Other (Specify)				TORY 9-9	-05 I	ALEXANDRI	A, VA
Ba	permit. Page Department Importent: if any injury or		21. Signature of Funeral Service Licensee	200413	(R	Name and Address AYMOND	FUNERAL.	SERVICE	E, P.A.	
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the deat	n. Do not ente	er the mode of dyin	g, such as cardiac o	ND 206 r respiratory arres	t,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	LUNE	- C	ANCE	ER			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):					
	Examine		Sequentially list conditions, b.							
7	be sit	ine	Tany, Isacing to mini solate cause. Enter Underlying Cause (Disease or injury	liarina út):						
4	and I-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):							
8760,	cate be executed physician and the burial-transit	a E		500 to (0, 43 4 50,1354	aonea or).				1	
387	phys phys s the	dicai	d.							
.O. Box 6	that the death certificated by the attending point detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ♣☐ No 9 ☐ Unknown	. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	ideath 3 🗀	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ry Day Year
<u>α</u>	es that igned by be deta	y Ph	Part II. Other significant conditions contr	buting to death but not res	ulting in the ur	derlying cause give	en in Part I.	23e. Did toba	cco use contribute to th	e cause of death?
rds	w requires been sign should be	ed by						1 ☐ Yes	2 No 3 Prob	ably 4 Dunknown
	The far ate has page 2	Completed						24a. Was an autopsy performe	24b. Were autoprior to condeath?	osy findings available inpletion of cause of
	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?				26. Place of Death			
of/	S S	မ	1 ☐ Yes 2 ☐ No		ER/Outpatien	3 DOA Othe	ar: 4 ☐ Nursing Hon	ne Mesideno	ce 6 Other (Specify)
U C		on:	27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Work	ς?	28d. Describe how	injury occurred	
Division Division	tend death tor: / the f	cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No			
	s after or Al	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, tarm, stre	et, factory, office	2	City or Town, S	et and Number or Rura. State) .	Route Number,
	To the Hospital or Attent within 24 hours after deatl To the Funeral Birector: completely filled in by the	edical	29a. Certifier (Check only one) 11 Certifying Physic 2 Medicel Examine	ian: To the best of my kno r: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the timestigation, in my of	ne, date and place, a pinion, death occurre	and due to the caused at the time, date	se(s) and manner as sta a and place, and due to	ated. the cause(s)
	To T	Σ	29b. Signature and title of certifier			29c. License	F3C2	29d	Date signed (Month, I	Jay, Year)
	8		30. Name and address of person who com	pleted cause of death (Item	1 23a) (Type, I	Print) Cofe	M	24	0646	
	Sta Registr	1000	31. Date filed (Month Par Year) 4 200	32. Agistrar's Signa	B A	and I				
				Jacobson 3	17					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 24a per verb., Government of Health and Mental Hygiene Certificate of Death Reg. No. 2005 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 29, 2005 Miller 9:15pm Edward Lee August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Frederick 9327-A Gravel Hill Road Woodsboro If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Indiana 8. Date of Birth (Month, Day, Year) Sep 16, 1932 7. Age (In yrs. last birthday) 5. Social Security Number Days Hours 1 M 2 □ F Sep 312-36-7643 72 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State Frederick Woodsboro Maryland 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9327-A Gravel Hill Road 21798 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Xes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify If Yes, Give Year or Dates: Specify: à Korea 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Veterinarian Animal Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Miller Herbert Ruth Vera Martin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 9327-A Gravel Hill Road, Woodsboro, MD 21798 Mrs. Marilynn Miller - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Smithsburg Crematory Aug 31, 2005 Smithsburg, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lightse 22. Name and Address of Easiford P.A. Funeral Home M00706 106 Fast Church St, Frederick, Maryland 21701 Pairt1. Enter the diseast, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he of failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physiclan/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only gne) Be examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 esidence 6 Other (Specify) 2 No 1 🗌 Yes 3□ DOA Medical Certification; To 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature a 29c. License number nd title o D58391 August 30, 2005 my 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 801 Toll House Avenue, #C-3, Frederick, Maryland 21701-4555 Sajjed Aziz, M.D.,

Examiner to the Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-transit Box 68760. attending | P.O. the ģ should be deta Division of Vital Records, page 2 s certificate filled in by the funeral director, this within 24 hours after death.

To the Funeral Director: After completely filled in by the funera

Funeral

Director

28a-f show

item 27 is marked other then "natural, or items 23a or 28a-f show other traumatic event, the Medical Examinan must be institled at

Health and Mental Hygiene. em 27 is marked other then

permit. Pages 1 and Department of Healt Important: If Item 2: any injury or other?

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) SEP 1 4 2005

		1	FOR	epartment of Health and M Certificate of Death	lental Hygier	2005 29969
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia		Douglas McSwain			23 2005 3:00 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. Cily, Town, or Location of Death		4c. County of Death
			Prince George's Hospital Cener	Cheverly		Prince George's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Davs Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director		3/7-70-0304 A 33	rs.	Jan. 17,	1952 Wash., DC
	pu 🖈	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
	Aaryla I sho	5		Cheverly		1 X Yes 2 □ No
	28a-	Directo	Maryland Prince George's 10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?
	with a or			20785		United States
	Jeath ms 23	Funeral	2906 Woodway Place 11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
(0	ifter o	Fun	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No 1 ☐ Yes Give		Alcan, etc.)	Black, White, etc.
9	72 hours after death with the Maryland netural; or items 23e or 28e-f show deat Examiner must be notified at	i by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		DIACK
	72 h	etec	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work		. Kind of Business/Industry
21215-0036	hen hen	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired) Dispatcher		Private
2	be filed within 72 hours after death with the Marylan tall Hygiene. de other then "netural", or items 23a or 28a-1 show event, the Madical Examinar must be notified at		17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	den Sumame)
Č	ntal l) Be	Arthur McSwain		Mary G	lambell
<u> </u>	2 should be 1 n and Mental I is marked o raumatic eve	၉		Mailing Address (Street and Number or Run		
	7 2 ± 5		Deborah R. McSwain/Wife	2906 Woodway Place,	Cheverly,	MD 20785
Baltimore,	ss 1 and 2 of Health a item 27 is		20a. Method of Disposition 20b. Place of	Disposition (Name of y, crematory or other place)	Date 20c.	. Location - Cily or Town, State
E			1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	ny Memorial Park 8/30	0/2005	Landover, MD
alti	permit. Pag Department Important: I any injury o	1	21. Signature of Funeral Service Licensee		tewart Fun	eral Home
m	83188		John T. Stewar III	4001 Benning Rd		sh., DC 20019
			23a. Part 1. Enter the disease, or complications that caused the death. Do n shock on heart failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	Pnysician	11.1	Immediate Cause (Final disease or condition a Liver Cance	r		Onset and Beam
	/Medical Examiner		resulting in death) Due to (or as a consequence of	of):		
	LAdillilei	_	Sequentially list conditions, b. Due to (or as a consequence of	of):		
	pet lisit	nine	cause. Enter Underlying Cause (pusease or injury	~~		
•	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of	of):		
8760,	ate be ex hysician the buria	dicai	d			
9	tificate ag phys as the	ledi				
Вох	leath certifica attending ph I for use as t	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	3 Ectopic pregnancy		23d. Date of delivery Month Day Year
	the att	by Physician/Me	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 9 Unknown	5 Other (specify)		Width Say
P.0	that the de ed by the detached	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I	23e Did tobaco	co use contribute to the cause of death?
	res tha	þ	Part II. Other significant conditions commonling to death but not resulting if	The underlying cause given in tracts.		2 No 3 Probably 4XUnknown
orc	w require been signal	eted				
Records,	e law has b	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
a F					1 ☐ Yes 2X	No 1 ☐ Yes 2 ☐ No
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou		th (Check only one)	e 6 ☐Other (Specify)
of	ਦ ≒ ¤	To	27. Manner of Death 28a. Date of Injury 28b. 1	Time of 28c. Injury at	28d. Describe how in	
on	Attending Phyrdeath. ector: After thi	tior	1 Xatural 5 ☐ Pending (Month, Day Year) 1 2 ☐ Accident investigation	njury Wark? M 1 ☐ Yes 2 ☐ No		
Division	Attending death.	ifica	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
	s afte	Certification:	Daniel g, dist (append)			228
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier (Check only one) 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge of examination and mannet, €20ed.	e, death occurred at the time, date and place, d/or investigation, in my opinion, death occur	and due to the causered at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	ithin 2	Med	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
	F 3 F ö			D 45881		8-23-05
1	(i)		30. Name and an ress of person who completed cause of death (Item 233)	Type, Print)	70 Hills 17	***
אוע	(B)		DR CARL JOHNSON 1221 MERC.	ANTILE LANE	LARGO,	MD 20114
	St Regist	ate rar	31. Date filed (Month, Day, Year) AUG 2 6 2005	book		

			State of Maryland / Department of Basistrar For State State Registrar Certificate of	Health and Menta	al Hygie	ne 2005	5 29970
			1. Decedent's Name (First, Middle, Last)		Reg.	No.	3. Time of Death
	Physicia		Frank Joseph Miller			Day Year	1-00 PM
	/Medic Examin			or Location of Death	gust 2	4. 2005 4c. County of Deat	th
	LAdiiiii	EI	22700 111 2	onsburg		Wicomi	CO
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year		ate of Birth fonth, Day, Ye		hplace (State or Foreign
	Director		160−28−3589 12M 2□ F 70 Yrs. Months Days	9/	20/193		nsylvania
	pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	ahov	7					1 ☐ Yes 2X No
	the N 28a-f	Directo	Maryland Wicomico Parsonsburg 10e. Street and Number 10f. Zip Code		100	Citizen of What Co	unto/2
	death with the Maryland ims 23a or 28a-f ahow	ᄒ		0.40	109.		arty.
	eath	Funeral		849 Hispanic Origin? (Specify Y ban, Mexican, Puerto Rican,	es or No-	USA 14. Race - Ame	rican Indian,
^	r Iten	Fun	1 Never Married 2 Married 1 X Yes 2 No		, etc.)	Black, White	
3	al', o	þ	3X Widowed 4 □ Divorced If Yes, Give Year or Dates: Army	Specify:		Specify:	white
5-0036	72 hours after natural', or Ite	Completed	15. Decedent's Education 16a. Decedent's Usual Occu	upation e during most of working	168	o. Kind of Business/	Industry
N	within ene. than "	nple	Elementary/Secondary (0-12) College (1-4or 5+)	ed)			
N	be filed within 72 hours after death with the Marylan ital Hygiene. Id other then "natural", or Items 23a or 28a-f ahow event. Its Medical Examination invalue recitified at		12 _ Career Milita 17. Father's Name (First, Middle, Last)	18. Mother's Name (First		S. Army	
and	ntal Hed of	Be	Ignatius A. Miller	Florence F			
Ž	should be nd Menta marked imatic ev	P	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street				Zip Code)
<u>8</u>	th ar			ston Rd., Mea			
<u>o</u>	f Heal		20a. Method of Disposition 20b. Place of Disposition (Name of	Date		. Location - City or	
Ē	Page ent o nt: If ry or		1 Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Gardens	¥ 8/26/05	ь н	lebron, MI	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Itam 27 Ia marked any injury or other traumatic en		21. Sunature of Funeral Service Licensee 22. Name and Address	ress of Facility Funeral Home			
ñ	perm Depa Impo any is		Varie H. Composo CFSP 501 Snow	Hill Rd., Sa	lisbur	ssional <i>P</i> v. MD 218	ASSOCIATION
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyi shock, or heart failure. List only one cause on each line.	ing, such as cardiac or resp	iratory arrest,	1,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition ACUTE EXACEBERATION	OF CHRONIC O	BSTRU	CTIVE LUNG	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of): END - STAGE E				571.5000
		_	Sequentially list conditions, if any, leading to immediate b. END - STAGE C. Due to (or as a consequence of):	1111 11 130			SYEARS
	ted	Examiner	cause. Enter Underlying Cause (Disease or injury				
	be executed ician and burial-transit	xar	that initiated events c. resulting in death) Last Due to (or as a consequence of):				
00/	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	call	(d				
Q	certificat Iding phy Ise as th					T	
gox	th cer endin	an/N	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnanc	cv		23d. Date of deli	
	e death he atten led for u	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _			Month	Day Year
Σ	d by t	Phy	9 Unknown	iron in Dant I	3a Did tabaa	an una contributo to	the cause of death?
as,	requires that the een signed by th nould be detache	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause grant HMPERTENSION	ivon in Faith.			obably 4 []Unknown
200	requ	etec					
rec	has b	ompleted			4a. Was an autopsy performed	prior to d	topsy findings available completion of cause of
	n: The licate har, page	O	25. Was case referred to medical		☐ Yes 2 🔀		2 No
Vital	Physician: The lav this certificate has ral director, page 2	o Be	avaminar?	26. Place of Death (Checkher: 4 Nursing Home 5		6 FlOther (Spec	xi6.1
Ö			27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Inju			njury occurred	any)
0		atlo	1 ⊠Natural 5 □ Pending (Month, Day Year) Injury Wo 2 □ Accident investigation M 1 □	ork?]Yes 2 □ No			
	8 0 O E	.2	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Lo	cation (Street ty or Town, St	t and Number or Ru tate)	ral Route Number,
VISION	ar d ract	Ξ	, (-p //				
DIVIS	ital or Attandi ins after death ral Diractor: F	Certification:					
DIVIS	Hospital or Att 4 hours after d Funaral Diract ely filled in by 1		29a. Certifier (Check only (Check only 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my or content of the basis of examination and/or investigation, in my or content of the basis of examination and/or investigation.	time, date and place, and du opinion, death occurred at the	e to the cause he time, date	e(s) and manner as and place, and due	stated. to the cause(s)
DIVIS	othe Hospital or Att thin 24 hours after d tha Funaral Diract mpletely filled in by	edical	(Check only one) Medical Examiner: On the basis of examination and/or investigation, in my one) and manner stated.	opinion, death occurred at the	he time, date	and place, and due	to the cause(s)
DIVIS	To the Hospital or Attan A within 24 hours after deat To the Funeral Director: completely filled in by the		(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my one and manner stated. 29b. Signature and title of certifier 29c. Licens	opinion, death occurred at the se number 46962	29d.	Date signed (Month	to the cause(s)
DIVIS	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by 1	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my one and manner stated. 29b. Signature and title of certifier 29c. Licens	opinion, death occurred at the se number 46962	29d.	Date signed (Month	to the cause(s)
DIVIS	To the Hospital or Att within 24 hours after d within 24 hours after d to the Funaral Direct completely filled in by 1	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my one and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. SHIRAZI, M.D. 31575 WINTER PLA	opinion, death occurred at the se number 46962	29d.	Date signed (Month	to the cause(s)
DIVIS	To the Hospital or Att within 24 hours after d within 24 hours after d To the Funeral Direct completely filled in by 1	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my one and manner stated. 29b. Signature and title of certifier 29c. License	opinion, death occurred at the se number 46962	29d.	Date signed (Month	to the cause(s)

			For State Registrar	State of M	arylan	d / Depa <i>Cei</i>	artmen <i>tificate</i>	t of H e of L	ealth a	and Me	ental H	ygiene Reg. No		5 29971
	Physici	an	1. Decedent's Name (First, Middle,								2. Date of D Month	Da		3. Time of Death
	/Medic		Karen Lillian								August			1905 p ^M
	Examir	er	4a. Facility Name (If not institution, g	give street and number)					Location	of Death			. County of D	
		4.	Suburban Hosp: 5. Social Security Number 6		no /ln ure	last birthday)	Bet!	hesda	a. If Under	24 Hrs	9 Date of B		ontgom	· · · · · · · · · · · · · · · · · · ·
	Funeral Director		043 34 8216 Usual Residence of Decedent	. Sex 7. Ag 1 ☐ M 2/2 F	64	Yrs.	Months	Days	Hours	Min.	8. Date of B (Month, D June 2		941 De	Birthplace (State or Foreign Country) rby, CT
	and		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Mary	ō	DC			Wash:	ingto	n						1 X Yes 2 ☐ No
	28a	Director	10e. Street and Number				10f. Zip	Code			····	10g. Cit	tizen of What	t Country?
	3a or	i D	1255 K St. SE					2000	3				USA	
	me 2	Funerai	11. Marital Status	12. Was Decedent Armed Forces		.S. 13. \	Vas Deced	fent of Hi	spanic Ori	igin? (Spec	ofy Yes or N	lo-		American Indian,
9	after or Ite	Fu	1 Never Married 2 Married				Yes		Specify:		iloani, etc.)		Specify:	vhite, etc. Black
93	ours arai',	d by	3 XWidowed 4 □ Divorced	Year or Dates:				- X					эреспу.	DIACK
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or Items 23e or 28e-f show to Medical Exemples Energied	Completed	15. Decedent's (Specify only highest of			16a. Deced	lent's Usua kind of wor OO NOT us	rk done d	uring mos	t of workin	g	16b. K	and of Busine	ass/Industry
121	within	mp	Elementary/Secondary (0-12)	College (1-4or 2yrs.		Admin		,		istani	٠		Pvt.	
	Hygie Hygie ther int, III		17. Father's Name (First, Middle, La			Admith	Locia				(First, Middl	e, Maiden		
Maryland	12 should be filled within h and Mental Hygiene. 7 is marked other than " traumatic event, the Me.	To Be	Edward G. Boros						Ed	lythe	Mende	z		
	ges 1 and 2 should be filed within 72 hours after death with the Marylar It of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, it a Medical Examinar Imagina notified at		19a. informant's Name/Relationship Edythe Session:								Route Num. aven,	-	06510	
altimore,	Pages 1 and ment of Healti ant: if item 27 ury or other t		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe			Place of Dispo emetery, cren enwood				Da 2-1-0!	ate 5		ocation - City hingto	or Town, State
Baltir	permit. Pages Department of Important: If i any injury or one		21. Signature of Funeral Service Lic		2 X t	22	. Name and	d Addres	s of Facilit	^{ty} Mars		s Fu	neral	Home of MD
			23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	ly one cause on each I	ine.	n. Do not ente	er the mode	e of dying	, such as	cardiac or	respiratory			Approximate Interval Between Onset and Death
10	Physician /Medical Examiner		disease or condition resulting in death)	a. <u>Metast</u> Due to (or as		Non-Sma	all C	ell	Lung	Cance	er			3 yrs.
	ped sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequ	uer Ce of).								
68760,	icate be executed physicien and s the burial-transit	icai Exar	that initiated events resulting in death) Last	c. Due to (or as	a consequ	uence of):								
387	phys phys the	edic		d										
Box	The law requires that the death certificate be executed sie has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	Ideath 3□	Ectopic pro Other (sp						23d. Date of Month	delivery Day Year
ls, P.O.	ires that the signed by a be detac	b	Part II. Other significant conditions	s contributing to death b	out not resi	ulting in the ur	nderlying ca	ause give	n in Part I.		_	tobacco u		e to the cause of death? Probably 4 □Unknown
0	w requir been si should	etec									-			
I Records,	The law ele has t page 2 s	Completed									peri	s an opsy formed? 2012 No	prior	
Vital	sician: T certificet irector, pa	Be (25. Was case referred to medical examiner?	W-12 20 12 1		- 1			26. Place	of Death	Check only	one)		
of \	Physician: this certifice ral director, i	၉	1 ☐ Yes ZX No	Hospital:		ER/Outpatien			4 🗆 190				6 ☐Other (S	Specify)
<u>_</u>		.: 0	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ıry ıy Υθαr)	28b. Time of Injury		8c. Injury Work			3d. Describe	how injur	ry occurred	
sio	Attending in death. ector: After by the fune	cat	2 Accident investigat 3 Suicide 6 Could not	he	415		М		es 2 🔲		26 1	(04	441	2 12 11
Division	2 2 2 2	Certification:	4 Homicide determine	28e. Place of In building, ei	iury - At no tc. <i>(Specif</i>)	ome, tarm, stre	eet, ractory	, office		2	City of To	(Street an Dwn, State	ia Number of 9)	r Rural Route Number,
	To the Hospital of within 24 hours all to the Funeral D completely filled it	Medical	(Check only one) Certifying 2 Medical Ex	Physician: To the best aminer: On the basis of and manner st	of examinat	wledge, death tion and/or inv	occurred (restigation,	in my op	inion, dea	d place, at	d due to the d at the time	causo(s) , date and) and manner d place, and c	at claid due to the cause(s)
	To the within to the comp	×	29b. Signature and title of certifier	1/2	U		290	License c8	number 8929				te signed (Me /28/05	onth, Day, Year)
~	10		30. Name and address of person who 5454 Wisconsin	Ave. #1300	death (Item Chev	y Chas	e, MD	20	815					
1	Sta Registr		31. Date filed (Month, Day, Year) AUG 3 0 2005	32. Registr	rar's Signa	porte	,							

8/25/05 1905 pm

KAREN L MCORE

			1 - Stata Registrar		artment of Health rtificate of Deat		ygiene Reg. No. 20 (15 2997
100	Physici /Medio Examir	al	Decedent's Name (First, Middle, Last) Owen Albert Moyer 4a. Facility Name (If not institution, give street and number)	per)	4b. City, Town, or Locatio	2. Date of E Month Aug -	Death Day Yes 28, 200 4c. County of D	3:45 P
	Funeral	iei	Salisbury Nursing and Reh 5. Social Security Number 6. Sex 7.	ab Center Age (In yrs. last birthday)	Sal:	isbury, Md. er 24 Hrs. 8. Date of B. Min. (Month, L	Wicomic Birth Day, Year) 9.	OBirthplace (State or Foreign Country)
	Director	or	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo		2/16/	1915 F	10d. Inside City Limits
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "neturel", or items 23e or 28e-f show or other traumatic event, the Madical Examiner matter mailing at	Funeral Director	10e. Street and Number 6180 Ox Bridge Dr.	Salisbury	10f. Zip Code 21801		10g. Citizen of What	Country?
9600	hours after de urei', or item il Examiner	þ	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Yes 2 If Yes, Give Year or Date	es? XINo es:	Was Decedent of Hispanic (f Yes, specify Cuban, Mexic 1 ☐ Yes 2X No Specify	can, Puerto Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, /hite, etc. White
21215-0036	filed within 72 Hygiene. Sther then "net ent, II's Madie:	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4)	(Give life.	dent's Usuaf Occupation kind of work done during m DO NOT use retired) chine Operat	or		ss/Industry
Maryland	2 should be filed withir and Mental Hygiene. is marked other then aumatic event, Ibe M.	To Be	17. Father's Name (First, Middle, Last) Orville Creighton Moye 19a. Informant's Name/Relationship (Type, Print)			ther's Name (First, Middlennie Mildred nnie Mildred nber or Rural Route Num	Kocher	e, Zip Code)
	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tra once.		James C. Moyer 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from St	20b. Place of Dispo	Ox Bridge sition (Name of natory or other place)	Dr., Salisb	20c. Location - City	1801 or Town, State
Baltimore,	permit. Pa Departme Importent any injury		21. Signard of uner Service Licensee	22	nlopen Crem, A Name and Address of Fac 1902 Ocean C	The Ullri	ch Funeral	Home
	Physician /Medical		23a. Pan 1. Enter the disease or complications that caus shock, or fleart failure. List only one cause the ear Immediate Cause (Final disease or condition resulting in death) Due to (a	ypertmire	er the mode of dying, such a		arrest,	Approximate Interval Between Onset and Death
68760,	eath certificate be executed attending physician and for use as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cause death).	as a consequence of):	ls			years
P.O. Box 68	The law requires that the death certificate tite has been signed by the attending phy age 2 should be detached for use as the	Physician/Medical		h 2 ☐ Fetal death 3 ☐ ht at time of death 5 ☐	Ectopic pregnancy	1	23d. Date of Month	delivery Day Year
	w requires that been signed b should be deta	by	Part II. Dther significant conditions contributing to deal Disbdes mellifus	th but not resulting in the ur	nderlying cause given in Par		tobacco use contribute	e to the cause of death? Probably 4 Unknown
of Vital Records,	iician: The law certificate has b rector, page 2 st	e Completed	25. Was case referred to medical		oo Di	per 1 \(\text{Yes}	opsy prior to death 21 No 1 Y	autopsy findings available to completion of cause of ? es 2 No
	ding Phys h. After this funeral di	To B	examiner? 1 Yes 2 Ino 27. Manner of Death 28a. Date of		Other •			pacify)
Division	To the Hospitel or Attenwithin 24 hours after deatl To the Funeral Director:	al Certification:	Duilding 29a. Certifier Certifying Physician: To the by	Injury - At home, farm, stre, etc. (Specify)	occurred at the time, date	City or To	(Street and Number or own, State)	on stated
•	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Examiner: On the basiand manner 29b. Signature and title of certifier	s of examination and/or inv	vestigation, in my opinion, do 29c. License numbe	eath occurred at the time	29d. Date signed (Mo	nth, Day, Year)
7	H3		30. Name and address of person who completed cause 610 Juliumans La	of death (ftem 23a) (Type, Casto) istrar's Signature	Print\	01		
*	Sta Registr	_	31. Date filed (Month, Day, Year) 32. By AUG 3 1 2005	istrar's Signature	rede			

State of Maryland / Department of Health and Mental Hygiene 200529973 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Maldonado 8 24 2005 1430 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Hospital Cheverly Prince George's 6. Sex 1 X M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min Yrs. 87 Director unknown Oct. 13,1917 Tampa, Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20717 238 12328 Firtree Lane USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 2yrs Business Owner Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked of Pages 1 and 2 should be unknown Virginia Maldonado 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) tof Health 12328 Firtree Ln. other t Maldonado/Daughter Bowie, MD 20717 mele 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location · City or Town, State 5 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of important: If any injury or once. Riverdale Crematory 8/29/05 4 ☐ Donation 5 ☐ Qther (Specify) Riverdale, MD 21. Signature of Tanaral Service Licenses 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20765 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Artenoscherokec andiovascular Diseas 7 COLLOS /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit to the Hospital or Attending Phyeician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? O HOLE Yes 2 1 🗆 Yes 24 hours after death.

Funeral Director: After this certificately filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide within 24 hours after de To the Funeral Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide 1 Contitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) De1852 AUGUST 25 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Queens bury Red Hyattou; 1/2 MD 2018 Devone 4203 31. Date filed (Month, Day, Year) 32 Registrar's Signature State AUG 3 0 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Death Day 28 2005 0245 **Physician** AUGUST Marie Bottash Moses /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death CENTER Examiner BROCKE GROVE REHABILITATION AND NURSING A SANLY SPRING MONTGOMERY 8. Date of Birth (Month, Dey, 6 / 0 7 / 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2X F 577-07-3206 Yrs. Wash.,D.C. 89 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumstic event, I'm Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Silver Spring Montgomery Md 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 20906 15300 Pine Orchard Drive #2E USA Funeral 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: White ģ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) I.B.M. Data Entry 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Helen Fillah Joseph Bottash 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 06 19a. Informant's Name/Relationship (Type, Print) 15300 Pine Orchard Dr. #2E Silver Spring, Md Ann Marie Moses/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Spurial 2 □ Cremation 3 □ Removal from State 8/31/05 Silver Spring, Md 4 □ Donetion 5 □ Other (Specify 21. Signature of Funeral Service Lice PHILIP D.RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical . ACUTE MYOCARDIAL INFARCTION MINUTES Examiner Examine COLONARY ettending physician and I for use as the bunal-transit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown HYPOTHYROIDISM MELLITUS: þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? this certificate has ral director, page 2 1 Yes 3 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 🗌 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time date and place, and due to the natise(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) edical 25n Cortifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number tugust 28,2005 STAFF PHYSICIAN 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TLALE BROOKE HOFFMAN U.D. 18100 SLADE SCHOOL ROAD SANDY SPRING 20800 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar DHMH 16 Rev 6/95

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			1 - For State Registrar	State of Mary	•	artment ertificate			nd M	1	Reg. No. 2	005	29976
	Physici /Medic	al	Decedent's Name (First, Middle, Las Daniel Joseph Aa. Facility Name (If not institution, give	Maloney		4h City T	own or l	ocation of	Death	2. Date of Dea Month Aug.	29 ^{Day} 20	05 ^{Year}	8:35 A M
	Examir Funeral	ier	13418 Daventry W 5. Social Security Number 6. Se	lay #J	n yrs. last birthday	Ger	mant	OWN If Under 24		8. Date of Birt (Month, Da June 2	Mon	tgome	lace (State or Foreign
	Director works	or	218-17-2419	10	1 Yrs. oc. City, Town or L German	ocation				June 2	9,1984		od. Inside City Limits
	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show may injury or other traumatic event, tre M. Jical Exertire trausite notified at ODGS.	eral Director	10e. Street and Number 13418 Daventry W	Jay, #J		10f. Zip 0	2087		0.10			d Stai	tes
9000	nours after de ural', or Item L'Exerciner o	Completed by Funeral	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		1 ☐ Yes 2	X No	Specify:	n? (Spe Puerto f	cify Yes or No Rican, etc.)	Spec	ace - Amend lack, White, city: Whit	etc. Ce
21215-0036	od within 72 h gjene. er then "natu , ine Medica	Complete	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12		(Giv life.	edent's Usual e <i>kind of work</i> DO NOT use None	done du retired)	ring most o			16b. Kind of	ne	dustry
Maryland	should be file and Mental Hy marked oth matic svent	To Be	17. Father's Name (First, Middle, Last) James Joseph Mal 19a. Informant's Name/Relationship (7)		19b. Mai	lina Address (Jan	et 1	(First, Middle, 111dred	Steub	er	(Code)
ore, Ma	ges 1 and 2 st of Health ar If Item 27 is or other trau		James Joseph Mal 20a. Method of Disposition 1 🛣 Burial 2 □ Cremation 3 □	oney-Father		8 Dave	ntry	Way	#J-(Germant	own, M	D. 208	374 own, State
Baltimore,	permit. Pa Departmen Important: any injury		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licental Service Li			22. Name and	Address	of Facility		Vol Fur -Gaithe		lome	
	Pnysician /Medical		23a. Rant fuller the disease, or composition of the	a. Pulmona	ry Edema		of dying,	such as ca	ardiac o	respiratory ar	rest,		Approximate Interval Between Onset and Death 5 Min.
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Pneumon Due to (or as a co	ia	al Hyn	oton	ia					5 Days
8760,	death certificate be executed e attending physician and od for use as the burial-transit		that initiated events resulting in death) Last	Due to (or as a co		ar nyp							
P.O. Box 6	that the death certifics ed by the attending pt detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	□Ectopic pred □ Other (spec						Date of delive	ery Day Year
	The law requires that the tee base been signed by the base been signed by the bage 2 should be detache	b	Part II. Other significant conditions of Diabetes Mellitu		ot resulting in the	underlying ca	use giver	in Part I.					ne cause of death?
al Reco		Completed	Malignant Melano	ma					_	1 ☐ Yes	rmed? 2 X No	prior to cor death?	psy findings available npletion of cause of
Division of Vital Records,	Attending Physician: r death. ector: After this certification the funeral director.	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	2 ER/Outpatie 28b. Time Injury		Other c. Injury a Work?	4 □ Nurs	ing Hom	(Check only only only only only only only only	lence 6 🗆 O		v)
Divis	Dir	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (5	Specify)					City or Tow	m, State)		l Route Number,
	To the Hospital within 24 hours of To the Funeral completely filled	Medical	29a. Certifier (Check only one) 1 X Certifying Ph 2 Medical Exam 29b. Signature and title of certifier	ysicien: To the best of m niner: On the basis of exa and manner stated	amination and/or i	nvestigation, i	t the time n my opii License	nion, death	place, a occurre	d at the time, o	date and place	and due to	the cause(s)
i	7		▶ Aandra Takai	Мр		250.		5543	3		29d. Date sign	29/05	**
_	5		30. Name and address of person who of Sandra Takai, MD	- 19234 Ge	rmantown	. ,	– Ge	rmant	own	, Maryl	and 20	874	
	Sta Regist		31. Date filed (Month, Day, Year) AUG 3 0 2	32. Degistrar's		marke							

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Registrar

		•	- For	partment of Health and Me ertificate of Death	ental Hygiene Reg. No. 2	005 20076
	Physici /Medic	al.	Decedent's Name (First, Middle, Last) LAURENCE M. MURTAGH		Date of Death Month Day AUG. 25,	year 2005 7:53 P M
	Examin	er	4a. Facility Name (If not institution, give street and number) WASHINGTON ADVENTIST HOSPITAL	4b. City, Town, or Location of Death TAKOMA PARK		nty of Death ONTGOMERY
	Funeral Director		5. Social Security Number 219-42-4391 Usual Residence of Decedent 6. Sex 1X M 2 F 7. Age (In yrs. last birthday 82 Yrs.	Months Days Hours Min.	DEC. 18,1922	9. Birthplace (State or Foreign Country) IRELAND
	Maryland 8-f show iffed at	ctor	10a. State 10b. County 10c. City, Town or I	TAKOMA PARK		10d. Inside City Limits 1 □XYes 2 □ No
	with the	Director	10e. Street and Number	10f. Zip Code		of What Country?
980	be filed within 72 hours after death with the Maryland tal Hyglene. Id other then "neturel", or Items 23e or 28e-f show event, the Medical Examinational to invilled at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	20912 Was Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto Ri □ Yes No Specify:	fy Yes or No- 14. R	J.S.A. ace - American Indian, lack, White, etc. city: WHITE
21215-0036	i within 72 houldene. Idene. I then "neture I're Wedical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) BARTENDER		Business/Industry ESTAURANT
Maryland 2		To Be C	17. Father's Name (First, Middle, Last) VINCENT MURTAGH	FI		JRRAN
Mar	sh and sm	13		ling Address (Street and Number or Rural R 32 LARGO CT., DAMASO		- 1
altimore,	Pages 1 and 2 ent of Health nt: If item 27 I		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, or		te 20c. Locatio	n - City or Town, State
Balti	permit. Pages 1 Department of H Importent: If ite eny injury or of		21. Signature of Funeral Service Licensee	22. Name and Address of Facility CHAMBERS FUNERAL HON 5801 CLEVELAND AVE.,	E & CREMATO	RIUM,P.A.
8760,	Physician / Medical Examiner the print-transit	ai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	tory Failu		Interval Between Onset and Death
P.O. Box 687	The taw requires that the death certificate it has been signed by the attending physionage 2 should be detached for use as the	Physician/Medicai		□Ectopic pregnancy □ Other (specify)		Date of delivery Month Day Year
	quires that on signed b uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use co	ontribute to the cause of death?
al Records,		Completed			24a. Was an 24t autopsy performed? 1 Yes 2 7 No	o. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
on of Vital	Attending Physician: The stratest. The stratest. ector: After this certificate his by the funeral director, page	tion; To Be	25. Was case referred to medical examiner? 1	of 28c. Injury at 28	Check only one) a 5 Residence 6 C d. Describe how injury occ	
Division	of or Attendii s after death. Il Director: At id in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office 28	of. Location (Street and Nur City or Town, State)	mber or Rural Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal of the best of the best of my knowledge, deal of the best of the best of my knowledge, deal of the best o	ath occurred at the time, date and place, an investigation, in my opinion, death occurred	d due to the cause(s) and I at the time, date and place	manner as stated. e, and due to the cause(s)
	To the Mithing To the	Σ	29b. Signature and titl, of certifier	29c. License number	29d. Date sign	aned (Month, Day, Year)
_	<i></i>		30. Name and address of puson who completed cause of death (Item 23a) (Type Ven Lync Structure)	Wathington	Advent	St HODD.
*:	Sta Regist		31'. Date filed (Worth, Day, Year) AUG 2 9 2005	all I		y

			1 For State	State of Ma	aryland / D	epar	tment of H	lealth an	d Mental Hy	giene		20	070
			Registrar 1. Decedent's Name (First, Middle, La	otl	(Cen	ificate of	Death	2, Date of De		2005	3. Time of	Death Death
	Physici	an	Richard Robert Mo						Month	Day	Year	1730	М
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City, Town, o	or Location of D	Death	2 4 4c. C	ounty of Death		
	Examin	CI	Peninsula Regiona	-	Center		Salisbu	ry		Wic	omico		
	Funeral Director		5. Social Security Number 6. S 219-34-3509		e (In yrs. last birtl	hday)_ (rs.	If Under 1 Year Months Days		Hrs. 8. Date of Bir Min. (Month, Da July 2.	y, Year) 3,1938	9. Birth Cou Mary	place (State of Intry) Land	r Foreign
_	iand ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loca	ation	<u> </u>		·-··		10d. Inside Cit	ty Limits
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3	death with the Maryland oms 23e or 28e-f show ir must be rivdiffed at	Directo	10e. Street and Number				10f. Zip Code			10g. Citize	n of What Cou	intry?	
2	ath wi	ral	4639 Coulbourn Mi				2180				SA		
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene thems 23e or 28e-f show them 27 is marked other tren" neturel; or Items 23e or 28e-f show other treumetic event, I'm Medical Franker must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 XYes 2 1 If Yes, Give Year or Dates:	1956 - 1960		as Decedent of H Yes, specify Cub ☐ Yes 2 No		? (Specify Yes or No Puerto Rican, etc.)		Race - Amer Black, White pecify: W		
Maryland 21215-0036	filed within 72 hours after Hygiene. other then "neturel", or Ite ent, The Medical Exertine	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5	16a.	Decede (Give ki life. Do	nt's Usual Occup ind of work done O NOT use retire	ation during most of d)	f working	16b. Kind	of Business/li	ndustry	
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and	be fill stal H ad ott	Be	17. Father's Name (First, Middle, Last						Name (First, Middle		umame)		
<u> </u>	should be and Mental is s marked o	٦	Robert Y. McGlaug		10h	Mailing	Address (Street		ggie Jenki or Rural Route Numb		Tour State 7	n Code)	
Z Z	id 2 sho Ith and 27 is m		Susan K. McGlaugh						Road, Sa				
ē,	s 1 ar f Hea ltem other		20a. Method of Disposition				tion (Name of atory or other pla		Date Date		tion - City or T		
Ë	Page nent o int: If		1 ☐ Burial 2 🕅 Cremation 3 [`4 ☐ Donation 5 ☐ Other (Speci		1		of Delmar	1	27/2005	Delma	r, Dela	aware	
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any injury or other tree		21. Signature of Fureral Service Lice	hsee	111	22. 7.0	Name and Addre	ess of Facility	ome, P. O.	Box	3171		
<u></u>	89 = 9	1	Teunial			112.	IZ Uld U	cean U	ity Koad,	Salis	sbury,	A. T. S. C. S. C. S. A. L. H. L. Y. Y.	
	Physician)	23. Phys. Enter the disease, or com- ock, or heart failure. List only Immediate Cause (Final disease or condition	plications that sed one sus a ach lir	the death. Do note.			ng, such as car	rdiac or respiratory a	rrest,		Approximate Interval Bety Onset and D	ween
i i	/Medical Examiner		resulting in death)	Due to (or as	a consequence o		level for	((
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760,	te be executed ysicien and e burial-transit		resulting in death) Last	Due to (or as	a consequence o	of):							
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P.O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physicien and age 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		ctopic pregnanc Other (specify) _	у		23	d. Date of deliv Month	,	/ear
	that the ed by detac	Ph	Part II. Other significant conditions	contributing to death b	ut not resulting in	the unc	lerlying cause giv	ven in Part I.	23e. Did t	obacco use	contribute to	the cause of d	eath?
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ta		a	25. Was case referred to medical					26. Place of	1 ☐ Yes		1 🗆 Yes	2 L No	
	> 0 0	To B	examiner? 1 🖫 es 2 🗌 No	Hospital: 1 Minpatie	ent 2 ER/Out	tpatient	3□ DOA Ctt	ner: 4 🗆 Nursi	ng Home 5 ☐ Resi	dence 6[Other (Speci	fy)	
0 _	- E		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Inju (Month, Day		ime of	28c. Injui	ry at	28d. Describe	now injury	occurred		
Sio	tending Ph leath. tor: After th the funeral	catle	2 Accident investigation 3 Suicide 6 Could not to		090			Yes 2 Ho		و (حرا			
Division of	or At fitter of Direct in by	Certification;	4 Homicide determined	28e. Place of Injude	ury - At home, far c. (Specify)	rm, stree	et, factory, office		28f. Location (City or To	em Ctatal	Number or Rur Mill		
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune		29a. Certifier 1 ☐ Certifying P	hysician: To the best	of my knowledge.	, death (occurred at the ti	me, date and p					,,,,,
	HOST PARTIES FOR	edical	(Check only 2 Medical Exa	miner: On the basis of and manner sta	examination and	d/or inve	stigation, in my	opinion, death	occurred at the time,	date and p	lace, and due	o the cause(s))
	To th withir To th comp	Me	29b. Signature and title of certifier	\			29c. Licens				signed (Month,	Day, Year)	
•			1 Chel				. ,	5049)		8/21			
			30. Name and address of person who	completed cause of d	eath (Item 23a) (Type, P	rint)	-1. /	114 ML	7	10		
		l de	31. Date filed (Month, Day, Year)	32. Regist#	ar's Signature	2//	JT _	WiSbu	114 114	21	801		
	Sta Registi		ANG &	9 2005	and D	K A	to de						

Physician	
/Medical	
Examiner	

Funeral Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23e or 28e-1 show any injury or other traumatic event. The Medical Examinat must be notified at once.

Baltimore, Maryland 21215-0036

Pnysician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

MATHEWS, WILLIAM

•	For State Registrar	State of Mar	yland / Depa <i>Cei</i>	artment of F rtificate of		•	giene _{Reg.} No	20	05	29980
ın	1. Decedent's Name (First, Middle, Last) William A. Ma	tthews				2. Date of De Month August	ath 23	200	Year 5	3. Time of Death 5:53 A. M
al er	4a. Facility Name (If not institution, give s Holy Cross Hosp			4b. City, Town, o		əath		County o		V
	5. Social Security Number 6. Sex		In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 H	Irs. 8. Date of Bir (Month, Da	_ [ace (State or Foreign try) Sylvania
or	Usual Residence of Decedent 10a. State 10b. County Maryland Montgome		Oc. City, Town or Lo							Od. Inside City Limits 1 X Yes 2 □ No
Direct	10e. Street and Number 320 Hannes Street			10f. Zip Code 20901			_	izen of WI		try?
Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Never Married	2. Was Decedent Ev. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:			ispanic Origin? In, Mexican, Pu Specify:	(Specify Yes or No lerto Rican, etc.)		14. Race	- America , White, a	etc.
npleted	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of t	working	16b. K	ind of Bus	iness/Ind	lustry
Be Con	17. Father's Name (First, Middle, Last) William F. Ma	5+ tthews		Attorney		Name (First, Middle,	Maiden	L aw Sumame)	
^L	19a. Informant's Name/Relationship (Tyr. Lisa S. Coval — Da	ne, Print)			and Number or	Rural Route Number	er, City o			
	20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 ☒ Re 1 □ Donation 5 □ Other (Specify)		20b. Place of Dispo	osition (Name of matory or other place	re)	Date	20c. Lo	ocation - C	City or To	
	21. Signature of Funeral Service License	tetten	ur 1	1170 Rock	ville P	erg Memori Pike, Rock	vi11	Chape Le, M	ls, arvl	Inc. and 20852
	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Conges	e death. Do not ent stive Hear consequence of):			diac or respiratory a	rrest,		D	Approximate Interval Between Onset and Death ays
luer	Sequentially list conditions, if any, leading to immediate full functions. Cause (Disease or injury		consequence of):	28						ays
edical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a o	ced Dement consequence of): l Fibrilla							ears
Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ac. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy				23d. Date Mont		ry Day Year
d by Ph	Part II. Other significant conditions con	tributing to death but	not resulting in the u	nderlying cause giv	en in Part I.		obacco u Yes 2		oute to the	e cause of death?
Complete						24a. Was autop perfo	an osy rmed?	pri	ior to com	psy findings available apletion of cause of
To Be	25. Was case referred to medical examiner? 1 Yes 2 No H	ospital: 1 🔀 Inpatient 28a. Date of Injury	2 ER/Outpatier		er: 4 🗆 Nursin	Death (Check only of g Home 5 Residence 128d. Describe I	dence	6 □Other)
Medical Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day)	/ear) Injury	Woi M 1□		28f. Location (Street an	d Number		Route Number,
al Certi	29a. Certifier 1—Certifying Phys	building, etc.	my knowledge, death				cause(s)	and man		
Medic	(Check only 2 Medical Examinone) 29b Sendard and title of certifier	er: On the basis of ea and manner state	xamination and/or in	vestigation, in my o						the cause(s) Day, Year)
	A . Name and address of person who con		th (Item 23a) (Type.		987			-29		
	AHMED NAWA		x 83816	9 GAI	THERS	BURG	2	0	200	383.

Registrar

31. Date filed (Month, Day, Year)

AUG 2 6 2005

32. Registrar's Signature

3 1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Physician 23, August 2005 10:15 AM Patrice Clune Malley /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Neme (If not institution, give street end number) Examiner Prince Georges Sacred Heart Home Hvattsville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yeer) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1□ M 2□ F Yrs Director March 26, Kansas 486-10-2571 Usuel Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County itam 27 is marked other than "naturel", or items 23s or 28s-f show other traumstic event, the Medical Exercises must be notified at 1 XYes 2 ☐ No Funeral Director Alexandria Virginia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 22032 1015 Crestwood permit. Pages 1 end 2 should be filed within 72 hours after death Department of Health end Mental Hygiene. Important: If Itam 27 Is marked other than "naturel; or Itema 23 any injury or other traumatic event, the Medical Exercition must 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No If Yes, Give X 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify Specify þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Lest) Be 2 Ellen McInerney John Clune 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 301 Summers Dr, Alexandria, VA 22301 Patrice Tighe/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Fairfax Memorial Park Aug 29, 2005 4 ☐ Donation 5 ☐ Other (Specify) Fairfax. VA 21. Signature of Funeral Servicy Licentee 22. Name and Address of Fecility Everly Wheatley Funeral Home 1500 W. Braddock Rd, Alexandria, VA 22302 28a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 3 wks Multiorgan Failure Examiner Due to (or as a consequence of): Physician/Medicai Examiner months Encephalopathy 5 cm efter death.

Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should ba detached for use as the bunal-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) resulting in death) Last Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 □ Probably 4 □ Unknown Multiinfarc Dementia þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No TL Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: Medicai Certification: To 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of Naturel 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital within 24 hours e To the Funeral Completaly filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end menner steted. 29a. Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier .05 60 eman

Registrar

State

3503 Perry St, Mt. Rainier, MD 20712

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

32/Registrer's Signature

Raman R. Tuli, MD

2 6 2005

31. Dete filed (Month, Day, Year)

AUG

			1 - For State Registrar	State of M	Maryland / Dep <i>Ce</i>	artment of H			iene _{eg. No.} 2005	5 2998
	Physici	an	Decedent's Name (First, Middle, I					2. Date of Deat Month	th Day Year	3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, g	ive street and number	-	4b. City, Town, or	Location of Death	August	4c. County of Deat	
E	Funeral Director		389-14-8482		ME Age (<i>In yr</i> s. last birthday 89 Yrs.	Rockvil If Under 1 Year Months Days		8. Date of Birth (Month, Day, June 4,	Year) Co.	ry hplace (State or Foreign untry) CONSIN
	ges 1 end 2 should be filed within 72 hours after death with the Marylend it of Heelth and Mental Hygiene. If item 27 is marked other than "natural; or Items 23a or 28e-f show or other traumatic event, it a Medical Examinat inval be redilized at	Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD Montgon 10e. Street and Number 806 Harrington I 11. Marital Status				ispanic Origin? (Sp	ecify Yes or No-	0g. Citizen of What Co USA 14. Race - Ame	ńcan Indian,
215-0036	hin 72 hours after a. an "natural", or ite Medicul Examire	Completed by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highest g	1 ☐ Yes 2 If Yes, Give Year or Date:	No s: 16a. Decc (Giv. life,	1 Yes 2 No Ident's Usual Occupate kind of work done of DO NOT use retired	Specify: ation furing most of work		Black, White Specify: W 16b. Kind of Business/l	hite
Maryland 21215-0036	2 should be filed within and Mental Hygiene. is marked other than "raumatic event, the Me	То Ве Соп	17. Father's Name (First, Middle, La Michael Peache	st)	Secr	etary		e (First, Middle, M La Bedma)	rk	
	Pages 1 end 2 shr hent of Heelth and int: if item 27 is m iry or other traum		19a. Informant's Name/Relationship Nancy Scott - Da 20a. Method of Disposition 1 ∑ Burial 2 □ Cremation 3	ughter	20b. Place of Disp	Carr Ave osition (Name of matory or other place	nue - Roc	kville,	20c. Location - City or 1	Town, State
Baltimore,	permit. Pages Depertment of Important: if it any injury or o		*4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lic	•		Heaven Cel	s of Facility Eac	kles-Spe	Silver Spri encer Funer ry, WV 254	al Home
8760,	Physician and /Medical Examiner transit	dicai Examiner	23a. Pan1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. First Indistrying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	as a consequence of): as a consequence of):	Λ	g, such as cardiac	or respiratory arre	sst,	Approximate Interval Between Onset and Death
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Records, P.	w requires that been signed b should be deta	þ	Part II. Other significent conditions Demo	contributing to death	but not resulting in the t	ınderlying cause give	on in Part I.		acco use contribute to	the cause of death?
Vital Rec	en: The law itilicete has be tor, page 2 sh	e Completed	25. Was case referred to medical				26. Place of Deat		prior to co death? No 1 Yes	opsy findings available ompletion of cause of
Division of Vi	or Attending P Ifter death. Director: After t in by the funera	Certification; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Actident investigate 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of I	ijury 28b. Time o	f 28c. Injury Work M 1 \(\)	at ? es 2 □ No	me 5 Resider 28d. Describe how	nce 6 Other (Speci w injury occurred	
	To the Hospitel within 24 hours a To the Funerei I completely filled	Medical (one)	Physician: To the best eminer: On the basis and manner	st of my knowledge, deal of examination and/or in stated.	vestigation, in my op	inion, death occurr	and due to the cared at the time, da	use(s) and manner as s te and place, and due t	stated. o the cause(s)
	To To To To To To To To To To To To To T	2	29b. Signature and title of certifier	Deus	set ni	29c. License		29	Aug 30, 2 Rockull	Day, Year)
	Sta	te_	30. Name and address of person who A Mend 31. Date filed (Month, Pay, Seat)	nivatta	t death (Item 23a) (Type) 2 (0) Restrar's Signature	seavel P	stv D Su	ite 330	Rockull	emp
	Registr		AUG 3 1	בטט	strar's Signature					

Physician Russell Oldham (Section Now) Labra (Section Now) Labra (Section Now) College (For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of H	lealth and f	Mental Hyg	iene 2005	29983
49 Seating From Financial Control Plant Seat Se		Physici	an	Decedent's Name (First, Middle, L.					2. Date of Deat Month	th Day Year	
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136. Spiles 16. County Maryland Montgomery Silver Spring 102 Code 103 Code 105 Co				578-03-7212		Ven			(Month, Day,	Year) Co	untry)
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Cardiac Arrhythmia Guesso or condition or resulting in death Due to (or as a consequence of):	Í,	д Д.Т.		snock, or neart failure. List one	nplications that cause one cause on each	d the death. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
Sequentially list conditions, if any, leading to immediate clause. Extended on the state of the				disease or condition							Chaet and Death
Section Sect		Examiner	_	Sequentially list conditions,	b						
Section Sect		uted d ansit	mlne	rany, leading to immediate cause. Enter Underlying Cause (clisses of liljur) that initiated events	Due to (or as	s a consequence or):					
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The state of the s	Vita	ician; sertifica ector, p	Be		Manaitali						21 <u>X</u> 1N0
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunitha Bhogavilli, M.D. 1220A East Joppa Road Towson, Maryland 21286 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature		Phys this ral dii	H- 1		28a. Date of Inju	ury 28b. Time of	1 3 DOX	4 X Nursing Ho			(y)
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunitha Bhogavilli, M.D. 1220A East Joppa Road Towson, Maryland 21286 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature	Sion	를 드 옷 걸	ation	2 Accident investigation	n	i <i>y Year)</i> Injury				,	
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DCV)54566 August 28, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunitha Bhogavilli, M.D. 1220A East Joppa Road Towson, Maryland 21286 State 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature		Hospit 24 hours 16 Funers letely fills		Check only 2 Medical Exa	miner: On the basis of	of examination and/or inv	occurred at the time restigation, in my opi	e, date and place, inion, death occurr	and due to the cau ed at the time, dat	use(s) and manner as s se and place, and due to	stated. to the cause(s)
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			State of Marylan	•	tment of F <i>ificate of</i>			and the second		
		1. Decedent's Name (First, Middle, Last)		Oeru	ilicate of	Dealii	2. Date of Dea	th 20	95	29984
	Physician	Hilda G.	O'Leary				Month	Dey	Year	مين مين دين الم
	/Medical					4b. Citv. Town, or		23, 200 4c. County of		10:45 a.m.
	Examiner	4e Fecility Neme (If not institution, give s		Claustina			And the same			• • • • • • • • • • • • • • • • • • • •
		Holy Cross Rehabilita			If Under 1 Year	Burton If Under 24 Hrs		Monte		
	Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. 95		Months Deys	Hours Min.	8. Date of Birth (Month, Day Aug. 23	, Year) , 1910	Coun	ace (State or Foreign try) ISYlvania
	Director	213-44-5899 Usuel Residence of Decedent	95				Aug. 23	, 1910	r em	ISYIVAIIIA
	and and	10a. State 10b. County	10c. City	y, Town or Loca	ation				10	Od. Inside City Limits
	f sho	Maryland Montgom	ery	N. Poto	omac					1 ☐ Yes 2 ☑ No
	with the Ma or 286-f s be notified	10e. Street end Number			10f. Zip Code			10g. Citizen of W	hat Coun	try?
	with or I	13917 Saddleview	Drive		20878			τ	JSA	
	72 hours after death with the Maryland natural; or items 23e or 28e-f show after Examiner must be notified at eted by Funeral Director	11. Marital Status	12. Was Decedent Ever in U,	S. 13. Wa	as Decedent of H	lispanic Origin? (S an, Mexican, Puer	pecify Yes or No-	14. Race		an Indian,
	ther diner	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2√2 No				o Rican, etc.)	Black	c, White, e	atc.
38	urs a		If Yes, Give Yeer or Dates:	1L	□Yes 2.131No	Specify:		Specify:	Whi	.te
ŏ	"natural", pleal Ex	15. Decedent's Educ	cation	16a. Decede	nt's Usual Occup	etion	d.i	16b. Kind of Bu	siness/Ind	lustry
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212	s within piene.	Elementary/Secondary (5-12)	2	Home	emaker			Own Hor	ne	
Þ	□ 工 章 E					18. Mother's Na	ne (First, Middle,	Maiden Surname	э)	
Maryland 21215-0036		Clinton Emory Gob	recht			Ellen	Sterner			
ary	d 2 should th and Men T is marke traumatic	19a. Informant's Name/Relationship (Ty)	oe, Print)			and Number or R		-		
	C = 0 F	Michael P. O'Lear	ry/ Son	13917	Saddlev	riew Driv	e, North	Potoma	c, MI	20878
Baltimore,	- I h +	20a. Method of Disposition		lace of Disposit	tion (Name of atory or other pla	се)	Aug. 26	20c. Location - 0	City or To	wn, State
E	0 = 5 C	1	emoval from State Gat	e of Heav	ven Cemete	ery	2005	Silver	Sprin	ng, Marylan
äti	# # # # # # # # # # # # # # # # # # #	21. Signature of Funeral Service License	90	22.1	Name and Addre	ss of Facility. Collins	Funeral			
ä	Dep impo	Kichard I M.	tio	500	O Univer	sity Blv	d, W, Si	lver Sp	ring,	MD 20901
		23a. Pert1. Enter the diseese, or complishock, or heart failure. List only or	cations that caused the deat	h. Do not enter	the mode of dyi	ng, such as cardia	or respiratory er	rest,	1	Approximate
	Observation	shock, or heart failure. List only or	e cause on each line.		•				1	Interval Between Onset and Death
	Physician /Medical	Immediate Cause (Final	22							10 Days
	Exeminer	disease or condition resulting in death)	Pneumonia		ence of:					.o bays
	<u> </u>		Circulato	ras a conseque						5 Years
	executed in and interest in Examine	Samuration list conditions		r es e conseque						
Ć	exec in an ial-tr	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	Arteriosci			vascular	Disease)	,]	ll Years
68760,	icate be executed physician and sthe bunal-transit	Cause (Disease or injury that initiated events	Due to (o	r as a conseque	ence of):					
					,				į	
Вох	eath certifi attending ifor usa as		l				41.4.4.0			
	death a atte	Part II. Other significant conditions con	tributing to death but not res	ulting in the und	derlying cause gi	ven in Part I.	23b. Did t	obacco use con	tribute to	the cause of death?
P.0	at the death certing by the attending letached for use a Physician/M						101	Yee 2.∏xNo	3 Prob	bably 4 Unknown
	as that igned to be date		reast, Dyspha	igia_						
of Vital Records,	law requires that the death certing as been signed by the attending so should be deteched for use a proletted by Physician/M							en autopsy rmed?	ava	are autopsy findings ailable prior to
ပ္ပ	The law requir sate has been s page 2 should								of o	mpletion of cause death?
æ	The la						4254	63 ZENU	1 🗆	Yes 2□ No
ta	artificat sctor, p					26. Place of De	ath (Check only o	ne)		
>	2 5 E	1 □ Yes 2X No	lospitel:	ER/Outpetient	3□ DOA Ot	her: 4 🖾 Nursing I	Home 5 ☐ Resid	lence 6 □Othe	er (Specif	()
	a Phy eral d		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo	ry at	28d. Describe h	now injury occurre	ed	
on	th: After e fun	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(World, Day Your)	піјагу		Yes 2 □ No				
Division	s after death. I Director: After to din by the funeral cartification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stree	et, factory, office		28f. Location (S City or Tox	Street and Number	er or Rura	l Route Number,
ă	tal or Attending P is after death. al Director: After t led in by the funera Certification:	Tomede	building, etc. (Specing	y /			5.1, 5.1.	,,		
	To the Hospital or Atte within 24 hours after de "To the Funeral Directo completaly filled in by the Madical Certific	29a. Certifier 1 ★ Certifying Physical Examin	ician: To the best of my kno ner: On the basis of examina	wledge, deeth o	occurred at the ti	me, dete and plece	s, and due to the	cause(s) and mai	nner as st	ated.
	he Hospi in 24 hou he Funer pletaly fil	one)	end manner steted.	and endrot inve	ougadon, in my	Spiritori, ueatri occi				
	within 2 To the comple	29b. Signature and title of certifier	1	1-1	29c. Licen			29d. Date signed	•	
	4	Meorge N.V	Jona sta	dem	6	012121		August	25,	2005
•		30. Heme end eddress of person who co	mpleted cause of deeth (Iten	n 23a) (Type, P	'rint)					
		George Sengstack	M.D. 3929	Ferrara	Drive,	Wheaton,	MD 2090)2		
	State	31. Dete filed (Month, Day, Year)	32 Registrer's Signe	eture Age	Les .					
	Registrar	AUU 4 5 ZUU	J Francis Och Car	To Aller Hall	Bellen					

DHMH 16 Rev 6/95

	1	For State Registrar	State of Ma	ryland /	Departme Certifica			, ,	iene •g. No 200	5 29985
Physicia /Medica	n al _	Decedent's Name (First, Middle, Las	MAIN					2. Date of Deat Month	25 200	5 1342 1
Examine Funeral		a figacility Name (If not institution, givi ININSWA KIGIO . Social Security Number 6. S	na Medi	CAL CO	nta inthday) If Und	Sali er 1 Year If I	Shury Under 24 H/s.	8. Date of Birth		Point Birthplace (State or Foreign Country)
Director	l	Jsual Residence of Decedent	□M 2∰F 88		Yrs. Month	B Days H	lours Min.	(Month, Day, 5/26/1		Maryland
e Marylar a-f ehow		oa. State 10b. County Maryland Wicomic	0		itland					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
with th	Dire	0e. Street and Number 514 Hayward Ave.			10f. Z	ip Code 2182	6	11	0g. Citizen of What USA	Country?
altimore, Maryland 21215-0036 iii. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artiment of Health and Mental hygiene. ortant: If Item 27 is marked other than "natural; or Items 23s or 28s-f show hury or other traumatic event, the Medical Examinat must be notified at	by Fur	1. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:			edent of Hispar ecify Cuban, M	nic Origin? (Speciferican, Puerto R	cify Yes or No- Rican, etc.)	14. Race - A	merican Indian, /hite, etc. White
Maryland 21215-0036 nd 2 should be filed within 72 hours aff tith and Mental Hygiene. 27 le marked other then "netural", or reaumetic event, the Medical Exam	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+	.)	Decedent's Us (Give kind of w life. DO NOT Presser	ork done durini	ng most of working	g	16b. Kind of Busine	ufacturing
Aaryland 2 2 should be filed v n and Mental Hygie 1 e markad other t raumatic event, til	To Be C	7. Father's Name (First, Middle, Last) Asbury Quinton T					Mother's Name Bernice		Maiden Surname)	
and 2 sho ealth and 1 m 27 le me ner traume		19a. Informant's Name/Relationship (Norma Jean Willi							City or Town, State VA 23395	e, Zip Code)
Baltimore, M parmit. Pages 1 and 3 Department of Health Important: If I lem 27 any Plury or other tr	2	Oa. Method of Disposition 1		20b. Place of cemete Wicon	of Disposition (Nary, crematory or	ame of other place)		ate 2	20c. Location - City Salisbur	
Balti parmit. Departm Importa any mu		1. Signature of Funeral Service Licen	see	Par CFSF	HOLLO	and Address of Way Fur	Facility Deral Ho	me Prof		Association
Physician	- 1	23a. Part1. Enter the disease, or comphock, or heart failure. List only immediate Cause (Final disease or condition	plications that caused tone cause on each line	he death. Do			de la cardiac or			Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a	onsequence	of):					
58760, icate be exacuted physicien and s the burial-transit	Examine	Sequentially list conditions, f any, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events resulting in death) Last	Due to (or as a							
68760, ificate be ex g physicien as the burial	edicai	•	d							
P.O. Box 68760, that the death certificate be exacuted ad by the attending physicien and detached for use as the burial-transit		FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal deati	n 3 ⊟Ectopic 5 ⊟ Other (s				23d. Date of o	delivery Day Year
S test	ລີ	Part II. Dther significant conditions o	ontributing to death but	not resulting	in the underlying	cause given in	Part I.			to the cause of death? Probably 4 ZUnknown
The The yage	Completed							24a. Was ar autopsy perform 1 Yes 2	prior t death	autopsy findings available to completion of cause of 7 es 2 No
/ita	2 2	25. Was case referred to medical examiner?	Hospital:			Othor	Place of Death			
hys his	ot : To	1 Yes 2 No 7. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	28b.	utpatient 3 0 Time of Injury	OA Other: 4 28c. Injury at Work? 1 Yes	28		nce 6 Other (S) w injury occurred	pecify)
Divisio	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, f (Specify)	arm, street, facto	ry, office	28	Bf. Location (Str. City or Town,		Rural Route Number,
		29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medicel Exam	ysician: To the best of niner: On the basis of a and manner state	examination a	e, death occurre nd/or investigatio	d at the time, da n, in my opinior	ate and place, an	nd due to the ca	use(s) and manner ite and place, and d	as stated. ue to the cause(s)
To th withir To th comp	2	29b. Signature and title of certifier			29	c. License nun	mber	29	d. Date signed (Mo	nth, Day, Year)
3	,	1 ch Con	1		7.	5000	5674		8 62660	No.
00		30. Na e all d address of person who	ome eted cause of dea	ath (Item 23a)	(Type Print)	ا بارد	n At	t, La	livbu.	nd lika
Stat Registra	ਓ		32. Remrar 2005	's Signature	Gran	2,				Month, Day, Year)

_			1 - State of Maryland / Dep State of Maryland / Dep Ce	artment of Health and M rtificate of Death	lental Hygid Reg	ene 2005 29986
	Physici	an	1. Decedent's Name (First, Middle, Last) Vivian E. F	ickeral	2. Date of Death Month	Day Year 3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	August 29,	2005 1:36 A M
	LXann	iei	Southern Maryland Hospital	Clinton		Prince George's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,)	9. Birthplace (State or Foreign
	Director		578-28-1486 1 M 2 F 80 Yrs. Usual Residence of Decedent		March 4, 1	
	yland now		10a. State 10b. County 10c. City, Town or Li	ocation		10d. Inside City Limits
	Ba-f s	ctor	Maryland Prince George's Upper Maryland	arlboro		1 ☐ Yes x2√ No
	with th	Funerai Director	100. Street and Number	10f. Zip Code	100	g. Citizen of What Country?
	ns 23	erai	13927 Bishops Bequest Road 11. Marital Status 12. Was Decedent Ever in U.S. 13.	20772 Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	USA 14. Race - American Indian,
Maryland 21215-0036	d within 72 hours after death with the Maryland Jiene r than "natural", or Itams 23a or 28a-1 show Its Medical Ever if sere use by medical at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	Rican, etc.)	Black, White, etc. Specify: Black
5-0	72 ho	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of worki	na 16	b. Kind of Business/Industry
121	within ene. than '	mpi	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) Manager		G. School System
d 2	filed Hygi thar		17. Father's Name (First, Middle, Last)	18. Mother's Name		
/an	o a a b	To Be	Harry Proctor	Effie	Calvert	,
lary	2 should and Men is marke aumatic			ng Address (Street and Number or Rura	I Route Number, C	City or Town, State, Zip Code)
	s 1 and 2 should if Health and Mer itam 27 is marke other traumatic		Lori Robinson / Daughter 1100 20a. Method of Disposition 20b. Place of Dispo	O Penny Ave. Clint		
nor	Pages nent of l int: If its iry or o		1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cre-	matory or other place)	20	c. Location - City or Town, State
Baltimore,	구두모금			eterans Cem. 09/02/2 2. Name and Address of Facility Coord		Cheltenham, Maryland
ä	permi Depa impo any ir		Wet Idaly 1 6	160 Oxon Hill Road Oxor	Hill, Mar	
	Fnysician /Medical	er, er også dette stoken.	23a Fart1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	er the mode of dying, such as cardiac o		
	Examiner		Sequentially list conditions b.			
	ed isit	iner	day, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events			
,	cate be executed physician and the burial-transit	Examin	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
8760,	ysiciar e buri	dicai	d			
9	ntifical ing ph	o ·	IF FEMALE:			
.O. Box	at the death certific by the attending p tached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
S, D	requires that een signed b	by PI	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
ord	w require been si should l				1 Tes	2 No 3 Probably 4 Unknown
al Record	The law ate has b page 2 sl	Completed			24a. Was an autopsy performe 1 ☐ Yes 200	24b. Were autopsy findings available prior to completion of cause of death? \$\text{No} 1 \subseteq \text{yes} 2 \subseteq \text{No}
Vital	Physician: this certifica ral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 Impatient 2 ☐ ER/Outpatier	26. Place of Death		2 Flore 40 - 41
οl		\vdash	27. Manner of Death 28a. Date of Injury 28b. Time of	IL 3 DOX 4 INDISING HOR	8d. Describe how	e 6 Other (Specify) injury occurred
sior	Attending r death. actor: After by the fune	atlo	2 Accident investigation	M 1 Yes 2 No		
Division	I or Atten after deat Diractor: I in by the	ertification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office 2	8f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	To tha Hospital or At within 24 hours after or To tha Funaral Dirac completely filled in by	O	29a. Certifier (Check only one) 20 Medical Examiner: On the bast of my knowledge, death and one retained and manner stated and manner.	n occurred at the time, date and place, a	nd due to the caus	e(s) and manner as stated,
	To tha Ho within 24 I To tha Fu completely	fedicai	and marrier stated.		ed at the time, date	and place, and due to the cause(s)
	To To Con	Σ	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
	4		30 Name indicates of person who completed cause of death (Item 23a) (Type,	Print) -	AC	COUSI 27, COUS
			P. Wisossy U.O. 12070 exp	LINE CENTER	WALDO	4F, Md. 20002
	Sta Registr		31. Palei (red 6/onth, Day, Year) 32. Registrar's Signature 32. Registrar's Signature			

			1 - For State Registrar	State of Marylar		artment	of Health and of Death	Mental Hygi	ene g. No. 2005	29987
	Physici	an	1. Decedent's Name (First, Middle, La	st)				2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Beryl M.	Poyser		1		8/28/200)5	7:00 P M
	Examin	er	4a. Facility Name (If not institution, give				wn, or Location of Dea	th	4c. County of Deat	
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs.	last birthday)	If Under 1		8. Date of Birth	MONTGOME 9. Birt	hplace (State or Foreign untry)
	Director		Usual Residence of Decedent	□ M 2XF 93	Yrs.		ays Hours Min	March 28	8,1912 Ja	maica
	anylar show	ž	10a. State 10b. County		ity, Town or Lo	/				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	28e-f	Director	Maryland Montgome	ry	Silver	Spring		10	g. Citizen of What Co	
	Sa or						0906	10		untry
	deeth	nera	12316 Dewey Road 11. Marital Status	12. Was Decedent Ever in U	J.S. 13.	Was Deceden	t of Hispanic Origin? (Specify Yes or No-	Jamaica 14. Race - Ame	
920	permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Heelih and Mantal Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f show any injury aucher treumatic event, the Madical Examinar must be notified at once.	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☑ Wildowed 4 ☐ Divorced	Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	ŀ	1 Yes, specify	Cuban', Mexican [*] , Puè No <i>Specity:</i>	rto Hican, etc.)	Specify:	ack
21215-0036	72 ho	Completed	15. Decedent's E (Specify only highest gra	ducation de completed)	(Give	dent's Usual (done during most of we	orking 1	6b. Kind of Business/	
7	within ene. than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NDT use	retired)		Orm Hama	
<u>0</u>	Hygi ent, I	Be Co	17. Father's Name (First, Middle, Last)	Homen	пакег	18. Mother's Na	me (First, Middle, M	Own Home daiden Sumame)	
Maryland	Aental Aental rked	To B	Charles Shield	ls			Margar	et Shak	es	
ary	2 should and his ma		19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (S	treet and Number or F	lural Route Number,	City or Town, State, Z	(ip Code)
	and seelth m 27 per tr		Claire V. Mitchel		12316	Dewey	Road Sil		.Maryland	
סר	To Hard		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State Par	cemetery, cre klawn	matory or other	r place)		Oc. Location - City or	
Baltimore,	artmer ortant Injury		* 4 □ Donation 5 □ Other (Special 21, Signature of Funeral Service Lice)	γ)		Park	Sep.	2,2005 R	ockville,M	laryland
Ba	Department Department Important Irr		21. Signature of Funeral Service Lice	refarker	F1	ancis	J. Collins ersity Blv	Funeral 1	Home, Inc.	MD 20001
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea one cause on each line.						Approximate Interval Between
2	Physician		Immediate Cause (Final disease or condition resulting in death)	a Chronic Obst	tructiv	e Pulm	onary Dise	ase	8	Onset and Death
	/Medical Examiner		resulting in dealin)	Due to (or as a consec	quence of):					
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec	quence of):					
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	c						
oʻ	e exection and an and and and and and and and and	Exa	resulting in death) Last	Due to (or as a consec	quence of):					
8760,	cate be executed physician and the burial-transit	dicai		d						
9	leath certifici attending pl	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregn	ancv				004 Date -6 dall	
Box	atten d for u	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	al death 3[⊒Ectopic pregi ⊒ Other (s <i>peci</i>			23d. Date of deli Month	Day Year
Ö.	at the de by the a tached t	hysi	9 Unknown	9□ Unknown						
Records, P.	as the gned	by	Part II. Other significant conditions (contributing to death but not re-	sulting in the u	nderlying caus	se given in Part I.		acco use contribute to	the cause of death?
000	aw require	Completed						24a. Was an	24b. Were au	topsy findings available
	The lavete has page 2	mo						autopsy perform	ed? death?	ompletion of cause of 2 No
Vita	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	The said of				ath (Check only one		
0	£ 5 m	0	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpatient 2 2 28a. Date of Injury	ER/Outpatier		Other: 4 ★ Nursing	Home 5 Residen	ce 6 Other (Spec	rify)
O	ding h. After funer	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year)	Injury	M 200.	Injury at Work? 1 ☐ Yes 2 ☐ No	20d. Describe nov	a infinity occurred	
Division	i or Attending Physician: efter death. Director: After this certifice I in by the funeral director.	Certification:	3 Suicide 6 Could not be determined		iome, farm, sti fy)	reet, factory, o	ffice	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospitel or within 24 hours efter To the Funeral Dircompletely filled in	Medical Ce	29a. Certifier 1 🔀 Certifying Pt (Check only one)	nysician: To the best of my known inter: On the basis of examination and manner stated.	owledge, deat ation and/or in	h occurred at to vestigation, in	he time, date and plac my opinion, death occ	e, and due to the cau urred at the time, dat	use(s) and manner as e and place, and due	stated. to the cause(s)
	o the	Mec	29b. Signature and title of certifier	and martini Stated.		29c. L	icense number	29	d. Date signed (Month	, Day, Year)
	- s - ō) Clumbal	Maynis		1	39793		August 2	9,2005
	1		30. Name and address of person who		т 23а) (Туре,	Print)			7108	177
			Christopher J. M			nce Ph	ilip Drive	Olney,Ma	aryland 2	0832
	Sta Registr		31. Date filed (Month, Day, Year) AUG 3 0 2	32 Registrar's Sign	ature &	wie				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2005 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Evelyn Snow Peters 4 2005 /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Sept. 26, 1909 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 1 1 F Maryland 95 Yrs. Director 214-38-2204 Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryla. Deperment of Heelth and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other treumatic event, if a Medical Exercit et mat Le notified at once. Annapolis Anne Arundel Maryland 1 ☐ Yes 2 XXIII Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 U.S.A. 4242 River Crescent Drive Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 200 No Specify: Specify. If Yes, Gird Year or Dates: White 3 ₩ Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **Teacher** Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Marquerite Julian Owen Snow Orittingham 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Manabastar Center, Vernont 05255 19a. Informant's Name/Relationship (Type, Print) 4783 Main St. Manchester Center, Vermont Thomas Peters/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition tX28urial 2 ☐ Cremation 3 ☐ Removal from State 8/30/2005 Cedar Bluff Cemetery Annapolis, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee John M. Taylor Funeral Home 22. Name and Address of Facility Swit 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HYroxIA **Physician** DAYI /Medical Due to (or as a consequence of): Examiner PLEURAL LYAG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed for use as the burial transit PNEUMONIA and resulting in death) Last Due to (or as a consequence ot) Division of Vital Records, P.O. Box 68760, ate has been signed by the attending physician page 2 should be detached for use as the burial FMLURF ACUTE DAY Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ COR UN AMRY ARTERY 1 Yes 2 No 3 Probably 4 Unknown Completed ATRIAL FARIL ATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 Yes 2 No 1 Yes 2 No Physician: filled in by the funeral director, Be 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Anpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 o 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After Hospitei or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, tactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide hours after within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) I bitoyl 00051437 Orans 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AAMC ANNAPOLIS 1BITOYE DARCY OKEOWO

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

AUG 2 9 2005

ORIGINAL

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month KEID 8 **Physician** /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City. Town, or Locetion of Death Examiner VALON MADOF Hagerstown Washington County If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 223-26-5079 1 □ M 2 🔽 F 8 2 Yrs 31-22 Director Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. ?7 is marked other then "naturel", or liems 23a or 28e-f shov traumatic event, tre Medical Exertinast to rediffed at 1 ☐ Yes 2 X No Director Virginia Fauguier Marshall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9788 Conde Road 20115 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race · American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. It: If item 27 is marked other then "naturel", or Itei 1 Never Married 2 Married 1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates: Specify: WHITE 1 ☐ Yes 2 ☑ No Specify: ۵ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Personal Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ္ပ Stanley Alford Ramey Lula Virginia Moffett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau John S. Reid, Jr. 6520 Wilson Rd. Marshall Virginia 20115 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State * 4 ☐Donation 5 ☐ Other (Specify) Orlean Cemetery Sept 3 2005 Orlean Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Endstage Immediate Cause (Final disease or condition resulting in death) demention Chronic **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2 ➡No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has I autopsy performed 1 ☐ Yes 2 3 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 100 ဂ္ 4☑Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this c 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification; 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hospitel or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

death with the Maryland

Baltimore, Maryland 21215-0036

within 24 hours a

State

29b. Signature and title of certifier

DF. VASA 31. Date filed (Mo

CM TENT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HALERSTOWN

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2 0 0 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** SEPTEMBER 8, 2005 SISTER CARMELITA ROCHE 1:15 A. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** FREDERICK EMMITSBURG ST. VINCENT CARE CENTER If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 □ M 2 🕅 F NOV.28, Director 1909 WASHINGTON, DC 201-44-1854 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show other traumatic evant, the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director MD FREDERICK **EMMITSBURG** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 335 S. SETON AVE. 21727 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. At If item 27 is marked other than "natural", or ite 1 ☐ Yes 2 ☑ No 1 X Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) RELIGOUS COMMUNITY Elementary/Secondary (0-12) College (1-4or 5+) SISTER OF NOTRE DAME LIBRARIAN 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be DAVID JAMES ROCHE MARY VERONICA HERBERT 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 ARTILLERY LANE, GETTYSBURG, PA. 17325 SISTER MARY ADELE WHITE 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State 6 permit. Page Department of Important: If any injury or once. 4 □ Domation 5 □ Other (Specify) SISTERS OF NOTRE DAME 9/12/05 ILCHESTER, MD. 21. Sign vu e of Muneral Service Licensee 22. Name and Address of Facility SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727 23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, phock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician were. c Cardio /Medical Due to (or as a consequence of) Examiner ten Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Examiner sician and burial-transit death certificate be executed Due to (or as a consequence of) attending physician for use as the hirria Division of Vital Records, P.O. Box 68760 Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🖾 No Year Dav 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☐ 1 Yes 2 No 3 Probably 4 Unknown lar diseas Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an certificate has autopsy performed? Yes 2 No 1 Yes director, Be 25. Was case referred to medical 26. Pface of Death (Check only one) examiner Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending 5 Pending Injury 1 X Natural after death. Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🔲 Homicide 24 hours a 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. 29c, License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) SEPTEMBER 9, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 8 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2005

State of Maryland / Department of Health and Mental Hygiene, Rag. No. 2005 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2005 Month Physician 3:28 P.M August 24, Ruth S. Ring /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country) Feb. 22, 1939 Missouri 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1□ M 2□ F Yrs. Feb. 66 Director 498-46-0289 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f ehow the Medical Exeminer must be notified at 1 Yes 2 □ No Rockville Montgomery Maryland Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or items 23a or 14 Windermere Court 20852 U. S. A. Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 □ Divorced "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker njury ether traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 12 should be fi h and Mental H 7 le marked of Radine Novoson Irven Dubinsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 le
any injurger other trau 14 Windermere Court, Rockville, Maryland 20852 Amy L. Murphy - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State Parklawn-Menorah Gdns 8/26/2005 Rockville, Maryland 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funaral Service Edward Sagel Funeral Direction, Inc. Donald (: 1091 Rockville Pike, Rockville, Maryland 23a. Part1. Enter the disease, or complications that caused the stath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEDSIS Physician 3 Lays /Medical Due to (or as a consequence of) Examiner Z months lung tatic Cancer Sequentially list conditions, if any, seading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Medical Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 2 Fetal death 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ØYes 2 □ No 3 □ Probably 4 □Unknown chronic osstructive pulmonary disease difficile 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? cystitis Psendomonas 2□ No 1 Yes 2 No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. М investigation 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \(\text{Homicide} \) within 24 hours after To the Funeral Dire 29a. Certifier P Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the names(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) DEGREE A SCROS, MO 9707 Medical Center Drive, #300 Modernille MD 2080 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2005 Registrar

Louise Randall 05-05627 RPD

J562 <i>i</i>		For State Registrar	State of	Maryland /		artment			nd Mental H	ygiene Reg. No		Ya sime	
Physic /Med		Decedent's Name (First, Midel LOUISE	dle, Last) RANDALL						2. Date of I Month Augus	Death Da	Z U (ear	2253 P M
Exam		4a. Facility Name (If not institution Johns Hopkins	-	ber)		46. City, 1 Balti		Location of			c. County ol		
Funera Directo		5. Social Security Number 218-18-7875 Usual Residence of Decedent	6. Sex 1 ☐ M 2 💢 F	'. Age (In yrs. last b 84	Yrs.	If Under Months	1 Year Days	If Under 24 Hours		Day, Year,	<i>;</i>	Birthplac Country MARY	
e Maryland e-f ehow	ctor	10a. State 10b. Count	y I BEACH	10c. City, To		ecation RATON						10d.	Inside City Limits
ath with th	ral Director	10e. Street and Number 7252 MONTRIC				10f. Zip	334			UNIT	tizen of Whi ED STA		? OF AMERICA
and 21215-0036 be filed within 72 hours after death with the Maryland tall Hygiene. of other than "natural", or Items 23e or 28e-1 ehow event, the Madical Est John Frant be instilled at	d by Funeral	11. Marital Status 1 Never Married 2 Mar Married 3 Widowed 4 Divorce	Armed Ford	₹XNo		Was Decedor If Yes, special		spanic Origi n, Mexican, Specify:	in? (Specify Yes or I Puerto Rican, etc.)	No-	14. Race - Black, Specify:	American White, etc. WH	
Maryland 21215-0036 at 2 should be filed within 72 hours aff the and Mental Hylgiene. 27 Io marked other than "natural", or traumatic event, the Medical Extra	Completed		nt's Education est grade completed) College (1-	4or 5+)	(Give life.	dent's Usual kind of work DO NOT use	k done d e retired)	urina most c	of working		ind of Busin		ıry
aryland 2. should be filed v ind Mental Hygie marked other umatic event, in	9	17. Father's Name (First, Middle ALFONSO GAB	RIELE					SA		le, Maider NKNOV	Sumame) VN)		
		19a. Informant's Name/Relation MARY ELLEN DI 20a. Method of Disposition		CER 5	5 OI	D OAK	ROA	D, WE	or Rural Route Num ST HARTFO	RD, C		17	
Baltimore, permit. Pages 1 at Department of Hea Important: If Item any Injury exphe-		1 Burial 2 Cremation 4 Donation 5 Other (Specify)		ery, crer WOOD	natory or oti PARK	central de la ce	ETERY		5 BF	ROOKLY	N, NE	EW YORK
Bal permi Depa Impo		23a. Part1 Enter the disease, of shock, or heart failure. Lis	or complications that can	used the death. Do	1	170 R	OCKV	TILE	PIKE ROC	KWITT		2085	2 proximate erval Between
Physician /Medica Examine		Immediate Cause (Final disease or condition resulting in death)	a Due to (o	r as a consequende) (e e of):	I1	40	Wie	4			On	nset and Death
8760, cate be executed physicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	r as a consequence									
P.O. Box 68 hat the death certifics d by the attending pt letached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes No	1 ☐ Live birt	ome of pregnancy th 2 Tetal deat nt at time of death m		Ectopic pre					23d. Date o Month	I delivery Day	/ Year
cords, P.O. I wrequires that the de been signed by the a should be detached it	þ	Part II. Other significant condit	ions contributing to dea	th but not resulting	in the ur	nderlying ca	use give	n in Part I.	_	tobacco u	3/		ause of death?
tal Recc an: The law ri ifficete hes be tor, page 2 sh	e Completed	25. Was case relerred to medical	al l					26 Diago et	1 Yes	opsy formed? 2 \(\) No	prior	e aulopsy to comple yes 2	findings available ation of cause of No
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the attending prompitately filled in by the funeral director, page 2 should be detached for use as	Certification; To Be	examiner? 17	Hospital: 1 Inn		Time of Injury	М	C. Injury Work 1 _ Y	4 □ Nursi	28I. Location	sidence how injur	y occurred	him	leace do de una Number,
To the Hospital within 24 hours e To the Funerel I completely filled	Medical C	29a. Certifier 1 Certifyi (Check out) 2 Medical	ng Physician: To the b I Examiner: On the bas and manne	is of examination a	je, death nd/or inv	occurred at estigation, i	t the time n my opi	e, date and p nion, death	place, and due to the occurred at the time	e cause(s)	and manne place, and	or as stated due to the	A(B)(s)
Tot To Com	×	29b. Signature and title of certific	Lenne				License).C.1				e signed (Mast 20		ŕ
	210	30. Name and address of person 31. Date liled (Month, Day, Year	who completed cause				eet,	, Balt	imore, Ma	rylar	nd 212	201	
, Regis	ate trar	AUG 26	2005	ce of the	100	Car.							

Harold Randall 05-05625 RPD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

)5(625		_ rot	partment of Health and Mental Hygiene ertificate of Death Reg. No.	
	Physici /Medic		Decedent's Name (First, Middle, Last) HAROLD RANDALL	2. Date of Death 2005 3. 2mm Grand Month August 19, 2005 2253 P	M
	Examir		4a. Facility Name (If not institution, give street and number) University Hospital	4b. City, Town, or Location of Death Baltimore 4c. County of Death	
	Funeral Director		5. Social Security Number 119-14-1684 6. Sex 1 M 2 F 7. Age (In yrs. last birthday 119-14-1684 81 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreig Country) MAR. 7, 1924 NEW YORK	gn
	he Maryland 28a-f ehow outlied at	Director	10a. State 10b. County 10c. City, Town or L FLORIDA PALM BEACH BOCA	RATON 1XI Yes 2 N	
36	be filed within 72 hours after death with the Maryland ital Hygiene. Ital Hygiene. In ital matural; or iteme 23s or 28s-f show event, the Medical Examinar must be notified at	by Funeral Dir	10e. Street and Number 7252 MONTRICO DRIVE 11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates:	10f. Zip Code 10g. Citizen of What Country? 33433 UNITED STATES OF AMERIC	<u> </u>
5212-0036	ed within 72 hour ygiene. ier then "netural t, the Medicel E.	Completed t	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 SENI	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) OR VICE PRESIDENT BROOKS FASHIONS	
Maryland	should be file nd Mental Hy marked oth imatic event	To Be	17. Father's Name (First, Middle, Last) MORRIS ZUKERCANDLE	18. Mother's Name (First, Middle, Maiden Sumame) CLARA (UNKNOWN)	
	ss 1 end 2 should to Ment and Ment item 27 is marked to other traumatic and			OLD OAK ROAD, WEST HARTFORD, CT 06117 Ostion (Name of Date 20c. Location - City or Town, State	
Baltimore,	Page ment in	}	1 ★ Burial 2 □ Cremation 3 ★ Removal from State 4 □ Donation 5 □ Other (Specify) KNOLLWOOD	PARK CEMETERY 08/23/05 BROOKLYN, NEW YORK	
g	permit. Departr imports any inji			22. Name and Address of Facility ANZANSKY GOLDBERG MEMORIAL CHAPEL, INC. 170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 181 the mode of dying, such as cardiac or respiratory arrest. Approximate	_
oʻ	Cate be executed hysician and physician and physician and the burial-transit	Examiner	shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Implementation to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	and Chest Dujuriey Interval Between Onset and Death	
.O. BOX 68/60	the death certifi y the attending iched for use as	hysician/Medical		□Ectopic pregnancy 23d. Date of delivery □ Other (specify) Month Day Year	
ras, r	= 00	by P	Part II. Other significant conditions contributing to death but not resulting in the u	anderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown	'n
al Records	The law ete has b pege 2 s	Completed		24a. Was an autopsy available prior to completion of cause of deals? 124b. Were autopsy findings available prior to completion of cause of deals? 124c. Was an autopsy findings available prior to completion of cause of deals?	e
JIVISION OF VITAL	To the Hospital or Attending Physicien: Th within 24 hours after death. To the Funerel Director: After this certificate completely filled in by the funeral director, pag	Certification; To Be	25. Was case referred to medical examiner? 27. Manner of Death 1 Naturat 5 Pending investigation 3 Suicide 6 Could not be determined 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28c. Place of Injury - At home, farm, st building, etc. (Specify)	of 28c. Injury at Work? M 1 Yes 2 No Assert re Vehicular accident	È
2	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical Cer	29a. Certifier (Chear or ly one) 1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner. On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, and due to the cause(s) and an er as stalled. exercise to the cause of the cause	
	To the To the comple	Mec	29b. Signature and title of certifier	29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) August 20, 2005	
	Sta Registr	-	21 Date filed (Month Day Year) 22 Pegistrada Simontus	nn Street, Baltimore, Maryland 21201	

State of Maryland / Department of Health and Mental Hygiene 2005 1 - For State Registrar 29994 Certificate of Death Req. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Ralph Gilbert Shipley **Physician** 9, 2005 1:20 P September /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Taneytown Carroll County 4126 Francis Scott Key Highway 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 11XM 2□F 213-16-0196 84 Yrs. Director 1921 Maryland 13, Usual Residence of Decedent 10c. City, Town or Location 10b County 10d. Inside City Limits 10a. State Item 27 is marked other then "natural", or Itema 23a or 28a-4 show other traumatic event, It a Medical Examinar must be rediffed at Maryland Carroll County Taneytown 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4126 Francis Scott Key Highway 21787 United States Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1941-1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White δ 1945 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 I Hygiene. other then "n College (1-4or 5+) Elementary/Secondary (0-12) zoning enforcer county zoning d 2 should be filed with and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Walter L. Shipley Helen Sarah Harman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Depintment of Health and Important: If Item 27 ts m any injury or other traum once. Hazel C. Shipley / wife 4126 Francis Scott Key Hwy. Taneytown, Md. 21787 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Sept. 13 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Taneytown, Maryland Mt. Pleasant Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 2005 22. Name and Address of Facility Skiles Funeral Home 21. Signature of Funeral Service Licensee 136 East Baltimore Street Taneytown, Md.21787 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MOS disease or condition resulting in death) /Medical Idi op Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or a consequence of) Examine the attending physician and hed for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown ۵ signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ð cate has been sig , page 2 should b 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred the Hospital or Attending Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 in an WI 30. Name a d dress of person who completed cause of death (Item 23a) (Type, Print) 7505 OSLER DR#409 USSIM MID 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 05 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year John Stewart Spicher 28, 2005 4c. County of Death /Medical August 7:30 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Homestead Manor Denton Caroline If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 26,1917 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 DM 2 □ F Director 88 221-07-2033 Delaware Usual Residence of Decedent filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. important: If item 27 is marked other than "netural; or items 23a or 28e-f show any injury or other traumatic event, the Medical Examinar must be natified at once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 XYes 2 ☐ No MD Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 410 Colonial Drive 21629 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 brakeman Penn Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Spicher Carolin Hudson P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hayes Conn, III (grandson) 150 Windover Turn Lancaster, PA 17601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State '4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Filheral Service Licels Gracelawn Mem. Park 9/2/2005 New Castle, DE 22. Name and Address of Facility McCrery Funeral Homes, Inc. under 3924 Concord Pike Wilm., DE 19803 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2101001016 myocardial /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medicai the for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hygar Jensici Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Was an autopsy performed?
Yes 2 To this certificate has page 2 1 ☐ Yes 2□ No 1 🗌 Yes the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 ther (Specify) Ass, whed 1 ☐ Yes 2 ☐ No Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 Tyes 2 □ No within 24 hours after death To the Funeral Director: A completely filled in by the fi 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeraf I 1 Secertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number OM DCC53355 29/2605 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21655 Buther 136 LEZIMM Are Walinga

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month 46 G/eg) 1 2005

32. Resistrar's Signature

			1 - For State Registrar	tate of Maryland	/ Depa	artment of He tificate of D	ealth and M	lental Hygi	ene	005	29996
ľ	Physici	an	Decedent's Name (First, Middle, Last) Andrew			vics		2. Date of Death			3. Time of Death
	/Medio	al	4a. Facility Name (If not institution, give stre		Zak	4b. City, Town, or I		August		ZUUD nty of Death	8:40P M
22			Charlotte Hall V	eterans Hom		Charlo	tte Hal	1	St	Mars	r's
25_	Funeral Director		5. Social Security Number 6. Sex 150-14-4750	2□F 7. Age (In yrs. last 78	birthday) Yrs.	If Under 1 Year Months Days	Hours Sept	8. Date of Birth Month Day, 2	(6°, 19	9. Birthpl	ace (State or Foreign try) NJ
	D		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Lo						3d Insido Cinatina
	be filed within 72 hours after death with the Maryland ntal Hygiene. Adother then "natural", or items 23s or 28e-f show event, the Madical Examinat must be malified at	tor	MD St. Ma			te Hall					od. Inside City Limits 1 ☐ Yes 2X No
	vith the	Funeral Director	10e. Street and Number	<u> </u>		10f. Zip Code		10	g. Citizen o	of What Count	try?
	eath v	erai	29449 Charlotte 11. Marital Status 12.	Hall Road Was Decedent Ever in U.S.	13 V	20622	nanic Origin? (Spe	oify Vos or No	US	A ace - America	na ladian
9	after d or iten	Fun		Armed Forces? 1 □XYes 2 □ No If Yes, Give		Vas Decedent of His Yes, specify Cuban		Rican, etc.)		lack, White, e	
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Maryland 2121	be de de de de de de de de de de de de de	To Be	17. Father's Name (First, Middle, Last) Andrew Szakovics	Sr		1	18. Mother's Name Anna K	(First, Middle, Ma	aiden Sum	ame)	
ary	s 1 and 2 should f Health and Mer tlem 27 is marke other treumetic	 -	19a. Informant's Name/Relationship (Type,	Print) 1	9b. Mailin	g Address (Street ar			City or Ton	m, State, Zip	Code)
	s 1 and 2 of Health item 27 i		Julie VanOrden/G			Box 65.					
nor	0 0		20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 □ Rem. 4 □ Donation 5 □ Other (Specify)			sition (Name of latory or other place)				n - City or Tov	
altimore,	permit. Page Dep riment o Importent: if any njury or once.		21. Signature of Funeral Service Licensee	M00945	22.	Veteran Name and Address AREHART	of Facility	9/6/05	Chel	tenha	m,MD
m -	8 8 2 5		23a. Part1. Enter the disease, or complicati	chas		$\frac{P.O.BO}{}$	-ECHOLS	FUNERA FA PLAT	<u>т но</u>	ME,P.	A.
Į	1		23a. Part1. Enter the disease, or complicati shock, or heart failure. List only one c Immediate Cause (Final	ause on each line.		\sim			ί, τ , τ τ τ		Approximate Interval Between Onset and Death
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Dao to for as a consequent	o oij.	ricula		noutr	nnl		1920
Ö,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a consequence	ce of):		1	Perm		4	10013
09/89	certificate be executed Iding physician and Ise as the burial-transit	dical	d								
ox e	eath certific attending p	n/Me		f yes, outcome of pregnancy					23d. D	ate of deliver	v
O. B	0 0 0	Physician/Med	in the past 12 months?	1□Live birth 2□Fetal dea 4□Pregnant at time of death 9□Unknown		Ectopic pregnancy Other (specify)			N	fonth [Day Year
ď	that the led by detacl		Part II Other significant conditions contrib	uting to death but not resulting	g in the un	derlying cause given	in Part I.	23e. Did tobac	cco use co	ntribute to the	e cause of death?
Records,	The law requires that the te has been signed by the age 2 should be detache	Completed by	Benigh Pros	static hy	per	tophe	<u> </u>	1 ☐ Yes	2 🗆 No	3 ☐ Proba	bly 4 Munknown
ecc	e law re has be e 2 sho	npie	Chronic und	forential	led	Schi 20	phrenia			prior to com	sy findings available pletion of cause of
Vital F		e Cor	25. Was case referred to medical					performe		death? 1 ☐ Yes 2	2□ No
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on of	ng l		1 Natural 5 ☐ Pending	8a. Date of Injury (Month, Day Year) 28b	. Time of Injury	28c. Injury a Work?	it 2	8d. Describe how			
DIVISION	f or Attendi after death. Director: A	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	8e. Place of Injury - At home,	farm, stre		es 2 No	8f. Location (Stree	at and Nun	ber or Bural	Route Number
á	pitel or A ours after lerel Dire	Certi	4 Homicide	building, etc. (Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town, S	State)		
	Hos Plum Pley	Medical	Check only 2 Medical Examiner:	in: To the best of my knowled On the basis of examination and and manner stated.	ge, death and/or inv	occurred at the time, estigation, in my opin	, date and place, a nion, death occurre	nd due to the caused at the time, date	se(s) and n and place	nanner as sta , and due to t	ted. he cause(s)
	To the within 2 To the complet	Ř	29b. Signature and title of certifier	01		29c. License r		29d.	Date sign	ed (Month, D	ay, Year)
			Jarrel /	Yan			5092		Augus	st 30	,2005
(BIVA		Parul Jani.M.D.	te cause of death (Item 23a		d.,Princ	o Frada	riol- MT	200	570	
B	Sta	te	31. Date filed (Month, Day, Year) AUG 3 1 200	32. Registrar's Signature	A IN	C. so.	e trede	LICK, MI) / Ö	
	Registr	ar	1,000 0 1 200.	Marie D	. 19	DE YES					

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			For State Registrer		State	JI WIAI Y		artment of F rtificate of				Reg. No. 2	005	29997
	D		1. Decedent's Name (First, Midd	dle, Last)							2. Date of De Month	ath Day	Year	3. Time of Death
	Physici: /Medic		Pauline G	•	Swah)					August			7:50p M
	Examin		4a. Facility Name (If not institution	on, give st	treet and nu	ımber)		4b. City, Town, o	r Location	of Death		4c. Cour	nty of Death	
			Kensington Nurs		& Reh			Kensing		0.111			tgomer	
	Funeral		5. Social Security Number	6. Sex	M 21X F		rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bin (Month, Da	y, Year)	Cou	place (State or Foreign intry)
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	and wc		10a. State 10b. County	ty		10c.	City, Town or Lo	ocation						10d. Inside City Limits
	Mary 1 sh	ğ	Maryland Howa	ard			Laure	1						1 ☐ Yes 21 No
	28a	rec	10e. Street and Number	aru			Daure	10f. Zip Code				10g. Citizen	of What Cou	intry?
	3a o	Funeral Director	7925 Belgaro F	Road				20	0723			USA		
	ms 2	ner	11. Marital Status		2. Was Dec Armed F	cedent Ever i	n U.S. 13.	Was Decedent of H		igin? (Sp	ecify Yes or No		Race - Amer Black, White	
ထွ	or Ite	F	1 Never Married 2 Mar	rried		2 🔯 No		1 ☐ Yes 2 ☑ No			1 110411, 010.)	Spe		, etc.
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21215-0036	d within 72 hours after death with the Marylan jenn and insture!, or items 23a or 28a-1 show ir than "nature!, or items 23a or 28a-1 show the Madical Examiner must be notified at	Completed	15. Decede (Specify only highe)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during mos	st of work	ing	16b. Kind of	f Business/II	ndustry
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Maryland	2 should be and Menta Is marked raumatic ev	T ₀	19a. Informant's Name/Relation		e, Print)		19b. Maili	ng Address (Street				er, City or Tov	vn, State, Zi	ip Code)
Ma	nit. Pages 1 and 2 should artment of Health and Men ortant: If item 27 Is marke Injury or giher traumatic 8.		Patricia Savas	ge	Daug	hter	3607	Woodridge	e Aver	nue	Silver	Spring	. Marv	land 20902
re,	of Health of Health item 27 I		20a. Method of Disposition			20	b. Place of Disp	osition (Name of matory or other place			Date	20c. Locatio		
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Baltimore,	permit. Pages 1 Department of H Important: If ite any Injuryorati		21. Signature of Funeral Service	e License	0,	. (-	2	2. Name and Addre						
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			resulting in death)		Due to	o (or as a con	s quence of):		Ne		15	4.10/	-	2902
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State of Maryland / Department of Health and Mental Hygiena 29998 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Aug. 26, 2005 **Physician** Slaughter Jamie 8:30р м /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Manor Care Silver Spring Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) 9,1959 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 579-84-0187 Months Days Hours 1**X** M 2□ F 46 Yrs. Wash., D.C. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits is marked other then "natural", or Items 23s or 28e-1 show sumatic event, the Medical Examinating the profile of all Silver Spring MD Montgomery 1 ☐ Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20902 11901 Georgia Avenue USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unemployed none or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname)
Margaret Brandom 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fili.
Department of Health and Mental Hy
Importent: If item 27 is marked oth
any injury or other traumatic event Bernard Slaughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 14635 Bauer Dr. Rockville, Md 20853 19a. Informant's Name/Relationship (Type, Print) Margaret Brandom/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crem. 8/30/05 Beltsville, Md ^¹ 4 □ Donation 5 Other (Specify) 21. Signature of peral Service Liceg PHILTY ADOSRINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Brain tumor year /Medical Due to (or as a consequence of) Examiner Multiorgan Failure Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physicien: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? tracheostomy 1 Yes 2 No 3 Probably 4 Unknown percutaneous gastostomy tube 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? Yes 2 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After or Attending 1 XNatural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No after death 2 Accident completely filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel 6 To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 29,2005 awan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10810 Darnestown Rd.#202 Gaithersburg, Md 20878 Raman Tuli MD. 32 Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

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2005

		State of Maryland / Department of State of Registrer State Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of	of Health and N	lental Hygie	-	29999
Physicia /Medic	al	1. Decedent's Name (First, Middle, Last) Elizabeth Swedberg 4a. Facility Name (If not institution, give street and number) 4b. City, Tow	vn, or Location of Death	2. Date of Death Month August	Day Year 24 200 4c. County of Dea	
Funeral Director	er	Heritage Harbour Health Center Annapo	olis	8. Date of Birth (Month, Day, Ye	Anne Arui	thplace (State or Foreign puntry)
Maryland 9-f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Anne Arundel Annapolis		Dec. 21,	1923 Nev	V York 10d. Inside City Limits 1 ☐ Yes 2 🛣 No
permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Heelih and Mental Hygiene. Importent: if tiern 27 is marked other than "naturel", or iteme 23a or 28e-f show any injury or other treumatic event, the Mcdical Examinar must be notified at one.	by Funeral Director	10e. Street and Number 580 Pinewood Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 Married 1 □ Pes 2 □ No		Un	Citizen of What Co ited Stat 14. Race - Ame Black, White	CES erican Indian.
iin 72 hours afi n "naturel", or	Completed by F	3 Wildowed 4 Divorced If Yes, Give Year or Dates: 1944–1945 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Or (Give kind of work of life, DO NOT use for life	ccupation one during most of work	ing 161	Specify: wh	nite /Industry
id be filed with lental Hygiene ked other that ic event, the N	To Be Com	College (1-4or 5+) Nurse 17. Father's Name (First, Middle, Last) Francis Bindulski		e (First, Middle, Mai	health ca iden Sumame)	are
1 end 2 shou Heelth and M em 27 is mar ther treumati	-	19a. Informant's Name/Relationship (Type, Print) Karen Lawhead/ daughter 20a. Method of Disposition 19b. Mailing Address (State 1) 19b. Mailing Address (S	reet and Number or Rur	al Route Number, C g ewater ,	MD 21037	
permit. Pages 1 Department of h importent: if ite any injury or ot ance.		1 ☑ Surial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) Crownsville Vet 21. Signature of Funeral Service Licensee 22. Name and Act	place)	9-05 C	rownsvill for Funer	e, MD
Physician /Medical Examiner pulsicieu and physicieu and sithe purial-fransit	edicai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line.		or respiratory arrest,		Approximate Interval Between Onset and Death
ath certif tlending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 5 Other (specify			23d. Date of del Month	ivery Day Year
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Attending Physicien: The Ir death, sector: After this certificate has stor: After this certificate has the funeral director, page	Certification; To B	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation M 3 Suicide 6 Could not be	Other: 4 Nursing Holling Holling At Work? 1 Yes 2 No	me 5 Residence 28d. Describe how i	injury occurred	
Hospitel or 4 hours efte Funerel Dir tely filled in t	edical Certif	4 Homicide determined 288. Place of injury a Kindme, farm, street, factory, on building, etc. (Specify) 29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in respectively.	ne time, date and place.	28f. Location (Stree City or Town, S and due to the caus red at the time, date	e(s) and manner as	stated
To the To the Complet	Med	29b. Signature and title of certifier 29c. Lic	cense number 792	29d.	Date signed (Mont	h, Day, Year)
Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) AUG 2 9 2005	231 Anna	apolis	บบอ ร	1401

	1	For State Registrar		State of	f Marylar	nd / Depa <i>Ce</i>	artment o rtificate	of Hea of De	ilth a eath	ind Me	ntal Hy	giene Reg. No.	2005	300	000
		1. Decedent's Name	(First, Middle	Last)						1	. Date of De Month	Day	/ Year	3. Time of	
Physicial /Medica		Mary		France	S		Stoner			h	VGUST	31	2005	3:30) HM
Examine				give street and nur	mber)		4b. City, To			f Death	•		County of Death		
		Coffman					Hager			24 Uso 1 -			Washingt		
Funeral Director		5. Social Security N 219–05–23	349	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. 90	last birthday) Yrs.	If Under 1 Months E		Under 2 lours		Date of Bio (Month, Da ept.	2, 1	914 Virg	olace (State of ntry) inia	r i-oreign
Pu ≱	}	Usual Residence of 10a. State	10b. County		10c, Ci	ty. Town or Le	ocation						·	0d. Inside Cit	ty Limits
n the Marylan r 28a-1 show	2													1 🗌 Yes	2 📉 No
Ne N 28a-1	Director	MD 10e. Street and Nur		ington	пав	erstow	10f. Zip Co	ode				10g. Citi	izen of What Cou	ntry?	
with with the control	2	11027 R		Drive				740				11	J.S.A.		
leath	era	11. Marital Status	Jacwood	12. Was Dece	edent Ever in U	J.S. 13.	Was Deceden	t of Hispai	nic Orig	gin? (Speci	fy Yes or N		14. Race - Ameri		
, Maryland 21215-0036 and 2 should be filed within 72 hours after death with the Maryland and 2 should be filed within 72 hours after death with the Maryland no 7 is marked othar than "natural", or Itams 23a or 28a-1 show her traumatic evant, the Modical Examinar must be notified at	by Funeral	1 Never Marri		Armed Fo ed 1 ☐ Yes If Yes, Giv Year or D	2 X) No ∕e		lf Yes, specify 1⊡ Yes 2∭X		nexican <i>pecify:</i>	, Puerto Hi	can, etc.)		Black, White, Specify: White		
Baltimore, Maryland 21215-0036 sernt. Pages 1 and 2 should be filed within 72 hours all opportment of Health and Mental Hygiene. mportant: If itam 27 is marked other than "natural", or any injury or other traumatic event, it is Medical Expensions.	Completed		15. Decedent			(Give	dent's Usual (kind of work of DO NOT use	done durin	n ng most	of working	7	16b. K	ind of Business/Ir	dustry	
withir than	dmo	Elementary/Seco	ndary (0-12)	College (1	I-4or 5+)		spersor					Ret	ail		
d 2 filled Hygii sthar	ပို	17. Father's Name	(First, Middle, I	Last)			<u> </u>		. Mothe	r's Name (First, Middle	, Maiden	Sumame)		
ld be ental ked c	To Be	William	O. Cur	ry					Bes	sie C	. Dev	iers			
re, Maryla s 1 and 2 should t Health and Men item 27 is marke other traumatic	-	19a. Informant's Na	ame/Relationsh	nip (Type, Print)		19b. Mail	ng Address (S	Street and	Numbe	er or Rural	Route Numb	oer, City o	or Town, State, Zip	Code)	
Ma ind 2 alth a		Charles	H. Ston	er/Son			5 Clint	_	ve.	, Hag	ersto	wn, M	D 21740)	
Baltimore, Maperint. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other tra		20a. Method of Dis		3 □Removal from	20b.	Place of Disp cemetery, cre	osition (Name matory or othe	of er place)	1	Da	te	20c. Lo	ocation - City or T	own, State	
Page nent cant of		1 ☐ Burial 2	□ Cremation 5 🎇 Other (S _i	pecify)Entomb	ment Re	st Hav	en Cem	etery	7 9	/3/20	005	Hag	erstown,	MD	
Batti perrat. Departr Imports any Inji		21. Signature of Fu	ineral Service	icensee		2	2. Name and	Address of	f Facilit	y Rest	: Have	n Fu	neral Ch	-	,
© 82 = 8		P 5.10	harll -	my									stown, M		
		23a. Part1. Enter t shock, or hea	he disease, or int failure. List	complications that o	aused the dea	th. Do not en	ter the mode	of dying, s	uch as	cardiac or	respiratory a	arrest,		Approximate Interval Bette Queet and I	ween
Physician		Immediate Cause disease or condition		a.	100	ueuti	N						7/	"O Jean	1
/Medical Examiner		resulting in death)		Due to	or s a conse	quence of):	eula	1 11		a (n			-,	ic/120	. /
4577		Sequentially list co	nditions,	b. Due to	(or as a conse	W	ewa	1 ac	w					10 pour	درا
pe psi	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	erlying injury		(or as a conse	que1100 01).									
8760, ale be executed obysician and the burial-transit	xan	that initiated events resulting in death)	5	c	(or as a conse	quence of):									
8760 sate be e physician the buris	dicalE														
687 687 difficate as the	edlo														
Box of death cert he attendin	Physician/Me	IF FEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 2 9 ☐ Unknown	months?	1 ☐ Live I	tcome of pregr birth 2 ☐ Fet nant at time of lown	al death 3	□Ectopic preg □ Other (spec		-				23d. Date of deliv Month	*	Year
ords, P.C Erequires that the peen signed by II hould be detach	/ Ph	Part II. Other signi	ficant condition	ons contributing to	eath but not re	sulting in the	underlying cau	ise given ir	n Part I		23e. Did	tobacco	use contribute to	he cause of c	leath?
ds, uires til	d by	DIA	Rels	Mellite	5						10	Yes 2	∃No 3 Pro	bably 4 □l	Jnknown
as b	Completed								_		perl	opsy formed?/	death?	impletion of c	available ause of
Vital F Vital F ician: Th	e Co	25. Was case refe	read to Tadion	1 1		-		26	E Diace	of Death	1 ☐ Yes (Check only		1 Yes	2 No	
	00	examiner?	No -	Hospital:	Inpatient 2[☐ ER/Outpatie	nt 3□ DOA	Other	_				6 ☐Other (Speci	fv)	
Par Par	n: To	27. Manner ea	th	28a, Date	of Injury	28b. Time		c. Injury at Work?			3d. Describe			,,	
EA: En	atlo	1	5 Pendin investi	9	nth, Day Year)	Injury	M	1 Tyes		No					
	ifica	3 Suicide 4 Homicide	6 Could determ	inod 289, Flat	e of Injury - At ling, etc. (Spec	home, farm, s	treet, factory,	office		28		(Street ar	nd Number or Rur e)	al Route Num	ber,
DIVI	Certification;	4 3 1 10 111 10 10													
Hos Pur 4 Pur edical	29a. Certifier (Check only one)		ng Physician: To the Examiner: On the band man											s)	
To tha l within 2 To the I	Me	29b. Signature and		Chan, m	0		29c.	License nu	66	55		29d. Da	ite signed (Month)	Day, Year)	-
SH-1		30. Name and add	ress of person	who completed cau	se of death (Ite	324	F. AN	TIE	TAI	n 5	T. H.	AGE	RSTOU	IN, 1.	nD
Sta Registr		31. Date filed (Mo.	SEP 0	1 2005	Registrar's Sign		boerke				7			/	
							-								